CANADA'S WEEKLY NEWSMAGAZINE

Maclean's

SPECIAL ISSUE

JUNE 15, 1998 ON DISPLAY UNTIL JUNE 21

A national survey shows where the health problems are

Ranking the health of Canadians and where the money goes

The Maclean's Health Report

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Maclean's
CANADA'S WEEKLY NEWSMAGAZINE

This Week

JUNE 15 1998 VOL 111 NO 24

Departments

Columns

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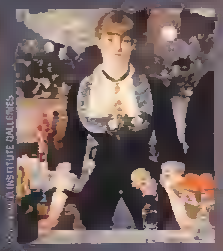
Features



From The Editor

Be healthy, go west

The dismantling of Canada's traditional health-care system, starting with the federal government's retreat from a leadership role in funding medicare, has created a national anxiety attack. At the community level—while governments were balancing their books—Canadians had to fight to get specialized treatment, they had to fight to get their loved ones into a hospital bed when that was essential, they had to fight to keep institutions open, and they have struggled to care for family members in a system that provides little support in the home. As well, the entire medical profession has been reeling under the strain of slash attacks on resources. As detailed in the *Maclean's* Health Report starting on page 14, there is, effectively, no true national health-care system in Canada. There is, to be sure, a reasonably high level of service and care, especially compared with the rest of the world. But the imbalances are striking. The four Atlantic provinces are at the rear of the pack in total spending per capita, in overall health—and in life expectancy. The data reveal, in fact, that as you move west across the map, the population is healthier and living longer. In that respect, it is the East that is alienated.

There are many surprises and some good news in the statistics, developed in partnership with the Ottawa based Canadian Institute for Health Information. Two provinces, in particular, have been subjects of much media attention about hospital closings—Saskatchewan and New Brunswick. Yet the survey shows that, relative to their populations, Saskatchewan ranks first in number of hospital beds, while New Brunswick tied for second. Prince Edward Island and New Brunswick are among the leaders in increasing the number of residential beds as an alternative to hospital stays—the wave of the future. One key lesson that emerges from the report is how a bad lifestyle can hinder chances of living a healthy life. We have seen the enemy—and it is us.

PHILL SNELGROVE/MACLEAN'S

Members of the Health Report team: (top row from left) Photo Editor Peter Bregg, Senior Writer Barbara Wickens, Edney, Researcher-Reporter Marcia Chen, Ferguson, and (bottom row) Caragata, Assistant Editor Danylo Hawaleshka, Marshall, Chief Copy Editor Virginia Taylor, Barrett

The special 26-page package was organized and edited by Assistant Managing Editor Robert Marshall. His team included Senior Writer Warren Caragata, Section Editor Mark Nichols, Assistant Art Director John Edney, Researcher-Reporter Sue Ferguson and Design Co-ordinator Buffy Barrett. The *Maclean's* Health Report would not have been possible without the partnership of CEO Richard Alvarez and his associates at CIHI in Ottawa. Clearly, much more information is needed for consumers of health care. But, as Alvarez notes, "we saw the Health Report as an excellent opportunity to contribute our wealth of information and expertise to broadening public understanding and discussion on key health issues. We believe it is an important first step in providing a statistical portrait of our health and health-care systems."

Robert Lewis

Newsroom Notes:

Life's achievements

DAVID CAMPEY

Newman, a tribute

Peter C. Newman, senior contributing editor of *Maclean's* and the editor who presided when the magazine went weekly in 1978, is the winner of the Lifetime Achievement Award presented by the fledgling Canadian Journalism Foundation in Toronto last week. The tribute honored Newman's illustrious career, which spanned his years as a reporter for *The Financial Post* and as Ottawa editor and later editor-in-chief of *The Toronto Star* (recipient last week of the Foundation's Excellence in Journalism Award). He joined *Maclean's* in 1956, became the Ottawa editor in 1960 and, after a stint with the *Star*, returned as editor-in-chief in 1971. By the time he left 11 years later, he had redefined the magazine, built up the staff, secured the circulation and the future of the magazine. Newman also is the author of 18 books, including *Renegade in Power* and *The Canadian Establishment*, which pioneered a new realism in the coverage of Canadian politics and business. Currently he is working on *Titans*, a book about the new Canadian establishment and continues his weekly Nation's Business column in *Maclean's*. In presenting the award, Sally Armstrong, editor of *Homemaker's* magazine, noted that Newman's "extraordinarily high standard" had set "an example for every journalist in the country."

The Mail


Pakistani joy: sanctions reek of hypocrisy

Nuclear big leagues

All the caterwauling and sanctimonious demands for trade and aid sanctions against India and Pakistan for exploding nuclear warheads reek of hypocrisy ("'The 'Islamic bomb,'" World, June 8). The Western democracies are falling all over each other trying to drum up trade with China, a country that not only has nukes to spare, but denies its citizens basic human rights. Russia, also, is a most-favored nation when it comes to trade even though it is armed to the teeth and unstable to boot. Unless the United States is prepared to scrap its own atomic arsenal, in the interest of creating a nuclear weapons-free world, it will continue to be ignored by developing countries determined to play in the military major leagues.

William Bedford
Toronto

Mahatma Gandhi must be turning over in his grave. That the country that produced Gandhi would be the new purveyor of Armageddon—I'm afraid I'll be sleeping less well at night.

Alain Kolt
Morden, Man.

India and Pakistan have spooked the existing nuclear powers who believe they have an exclusive monopoly over such weapons. There is no doubt that sanctions will cause setbacks in these countries, but they also might serve as an impetus to their people to pull up their socks, work harder and not depend so much on foreign aid. Still, I hope one day there will be a mutual defence treaty like NORAD among India, China and Pakistan, and that none of these countries will have to channel their limited resources to testing nuclear weapons, deprive their people of the basic necessities of life and contaminate their environment for decades to come.

Suresh Kurl
Richmond, B.C.

Defensive manoeuvres

Despite my personal experience described in your May 25 cover, "Rape in the military," I do not believe that sexual harassment, assault and/or rape are any more prevalent in the military than in any other cross section of society. Unfortunately, the old adage holds true in the military as it does anywhere else: a few bad apples spoil the bunch. For all that is written in an article, there is much left unsaid from the interview once it is edited. I had hoped that your coverage would show that there is a real need to focus on the investigative and trial process. I was fortunate to have had extremely supportive and professional military police investigators, but found the court martial process traumatizing. Anyone considering joining the military should not be unduly alarmed by the unfortunate stories of a few. A military career can be a very rewarding venture, and I hope those inclined to put themselves above the law will be prosecuted, retire or think twice.

Capt. Catherine Newman (Ret.)
Orleans, Ont.

As a then-single servicewoman posted to Camp Wainwright from 1990 to 1995, I take exception to your allegations regarding the safety of the base and Battle School in 1994. All recruits, regardless of gender, are subject to a curfew while undergoing training. As for the sentries and soldiers with pickaxe handles, it simply did not happen. For five years, I called the base my home. I walked freely around it any time of day or night, often alone, and not once felt my safety in jeopardy.

Cpl. Dorothy (Lightbody) Holdaway,
Upper Sackville, N.S.

I have spent more restless nights as a result of your articles than at any other time in the 38 years I served in the Canadian Forces. On the one hand, I congratulate you for making the public aware of a major problem in the military. On the other hand, I deplore, indeed, consider it irresponsible that your editor would make statements that the situation in the Canadian Forces is so bad that a servicewoman "needs a male goon to get justice" and that "legions of women have declined to come forward" ("A wake-up call for the brass," May 25 and "The Forces have a problem," June 1). Equally, his solution to the problem—"a small blue-ribbon panel of three independent-minded people, with a mandate to tour the country in the next two months to hold hearings"—is cute, but of no practical value. This is the worst possible

OVERFLOW

The e-mail started within hours of the publication of the May 25 cover package, "Rape in the military." The flood included letters from military women who decided to reveal their experiences of sexual assault after reading similar accounts in the magazine. A second cover story, "Speaking out," generated even more mail. Within three weeks, *Maclean's* received 150 letters. Several writers criticized the magazine for bringing the military unfairly into disrepute. Others volunteered to be interviewed or offered praise, including one woman who wrote: "I feel better knowing that I am not alone." *Maclean's* reporters are preparing new stories, but the magazine also has put several willing callers in touch with investigators anxious to reopen their cases.

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Maclean's welcomes readers' views, but letters may be edited for space and clarity. Please supply **name, address and daytime telephone number.** Submissions may appear in *Maclean's* electronic sites.

June 21 National Aboriginal Day

Share *in the* Celebration

On June 13, 1996, Governor General Roméo LeBlanc proclaimed June 21 as National Aboriginal Day. The Royal Proclamation stated that, "... the Aboriginal peoples of Canada have made and continue to make valuable contributions to Canadian society and it is considered appropriate that there be, in each year, a day to mark and celebrate these contributions and to recognize the different cultures of the Aboriginal peoples of Canada."

National Aboriginal Day also supports initiatives outlined in *Gathering Strength - Canada's Aboriginal Action Plan* which sets the direction for a new course among governments, Aboriginal groups and organizations and the private sector based on the principles of mutual respect, recognition, responsibility and sharing. National Aboriginal Day celebrations are built on partnerships that foster understanding of the diverse cultures of Aboriginal people across Canada.

The designation of this day recognizes the contributions of First Nations, Inuit, and Metis people to the development of Canada. It also supports the United Nations International Decade of the World's Indigenous People (1994-2004).

The federal government is encouraging all Canadians to celebrate, learn about, and honour Aboriginal peoples' cultural heritage on June 21.

The images in this photo montage reflect the diversity of Aboriginal peoples' cultures past and present:

- An archival photo of Inuit hunters wearing caribou skin clothing in a kayak made from seal skin.
- An Inuk woman wearing a sunburst parka, designed and produced by Inuit women on Holman Island in the Northwest Territories.
- The Métis sash, a traditional item of clothing that today symbolizes the pride and honour of the Metis people, who helped to foster understanding between Europeans and Aboriginal peoples.
- First Nations children participating in a powwow, a type of celebration that is held by First Nations across North America.
- An archival photograph of Chief Poundmaker, the respected nineteenth century leader of the Plains Cree people.

National Aboriginal Day is a day for all Canadians.
Share in the celebration this year and every year!

For further information, telephone (819) 997-0380
Web site: http://www.inac.gc.ca

Canada

THE MAIL

time for the Canadian Forces to have another independent inquiry "independent-minded" to me means that those three members will not have the slightest idea of what the challenges in the military are really like. Also, it implies a mistrust of the incumbents. If your editorial policy is to give a balanced view, then it must give the military some credit for being able to deal with its problems.

Lt.-Gen. J. K. Dangerfield (Ret.)
Kelowna, B.C.

I commend Maj. Dee Brasseur for speaking out about sexual harassment and for all the groundwork that she has laid for women in the Canadian air force ("Speaking out," Cover, June 1). I would, however, like to set the record straight regarding Snowbird tryouts. Pilots serve two years on the team with half being replaced each year. The remaining pilots are the selection committee for the following year's applicants. I was on the team during one of Dee's attempts to get a tryout and in that particular year we had approximately 80 applications for the eight positions. During the selection phase, we looked at everything from flying/personal evaluation reports, experience, physical fitness to compatibility with the existing team members. With so many applicants and such a large talent pool to choose from, we selected the eight that were, in our opinion, the best possible pilots to "fly off" against each other for the four positions. Gender was never an issue, only ability.

Joe Parente
Snowbird 2, 1986-1987
Hong Kong

Part of the reason for the low morale in the armed forces is the full integration of women in combat units. The idea of females fighting side by side with males is mind-boggling to anyone with any experience of war. Thousands of Canadian women served overseas in the Second World War, but not in combat. If they want to be at the front and in the fighting forces—and some of the toughest sergeants I ever met were in the Canadian Women's Army Corps—they should have their own units. That would solve all the present problems. Putting female and male sailors in a submarine where there is no privacy is the sort of idiocy that could only come from a defence department subverted by the politically correct. If women want to be submariners, they should have their own submarine.

Peter Stursberg
West Vancouver, B.C.

Worst marine disaster

I have greatly enjoyed your recent articles on the Titanic, both on the real and the Hollywood version, and in particular the auxiliary article on the SS Atlantic in the June 1 issue ("Revisiting a seaside graveyard," Travel). However, I must point out that neither the Atlantic nor Titanic ever held the "dubious honor of being 'the world's worst single-vessel marine disaster.'" That distinction belongs to the steamship Sultana, which exploded on the Mississippi River on the night of April 27, 1865, while transporting over 2,400 Union soldiers home after their release from Southern prison camps at the end of the Civil War. Of that number, approximately 1,800 died, nearly 300 more than on the Titanic and three times the number on the Atlantic. As documented by Jerry O. Potter in his book *The Sultana Tragedy*, there are many reasons that this greatest of all maritime disasters has remained relatively obscure. First, timing. This disaster occurred within weeks of the end of the Civil War, the assassination of Abraham Lincoln, and the subsequent killing of John Wilkes Booth, relegating this major event to minor status even at the time. Second, social standing. The victims were largely sons of Midwestern farmers and artisans—no East Coast aristocrats to command attention. Most important, however, was the fact that the irresponsible events leading up to the tragedy implicated the army, major manufacturers, and several state and federal officials, including Lincoln himself. Perhaps, in time, this subject will be made into another blockbuster movie, or, more likely, as with *Amistad*, will again demonstrate that films about ships with poor passengers don't sell.

William Shookhoff,
Toronto

Tempest in a hospital

In 1990, I rode my bicycle across this great country and found tremendous anger at former prime minister Brian Mulroney and the premiers for promoting the Meech Lake accord without consideration of the opinions of the public. I experienced that same anger in Ottawa in recent weeks over the appointment of David Levine, a onetime separatist candidate, to head the new Ottawa Hospital ("Condition critical," Canada, June 1). As both the Bloc and Parti Québecois advocate destruction of this great country, that makes them traitors in my opinion. It is frustrating that there is nothing we can do except withdraw our financial support to the hospital.

Peter M. Jones,
Gloucester, Ont.

As an Ottawa resident who has recently spent many months in a Montreal hospital because the specific medical services I required were not available in Ottawa, I am amazed at the shortsightedness of my fellow citizens who claim that they will no longer contribute to our newly amalgamated hospital because of the Levine affair. Don't they realize that their contributions are an important element in allowing our local hospitals to purchase leading edge equipment and provide a broad range of health-care programs? Or would they simply move to the nearest major centre where such services are available—which, in this case, just happens to be Montreal?

Alan Robinson,
Ottawa

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THE MAIL

For sale by owner

I read your article "Lower fees for the asking" (Personal Finance, May 18) with glee since I have sold my home twice without the help of a real estate agent. It is no harder to sell on your own than to sell through an agent. The trick is to always have the house "show ready", the other trick is to ask for a realistic amount. People are under the misconception that you have to have a real estate agent for legal reasons. Regardless of using an agent or not, you always need a lawyer. Real estate agents are simply the salespeople.

John Preston
Aurora, Ont.

The price of freedom

Robert Lewis's editorial "Playing petty politics" is on the mark (From The Editor, May 18) except for his mention of "more than 5,000 French-Canadians" who were killed or injured in Canada's war effort. The exact figure is difficult to give, but the total would be much closer to 10,000 if one considers that for every man killed, there were close to and sometimes more than three wounded. The casualty lists to which I have had access as a professor reveal that in the four French-speaking infantry units at the "sharp end" in battle, about 1,300 officers and men were killed and close to 4,000 were wounded. This excludes the hundreds of French Canadians who served in non-French units, such as the North Shore (New Brunswick) or Ontario's Essex Scottish regiments. It also does not take into account those who served in non-infantry units, such as artillery, armor or support services. The navy had its share of such fatalities, as did the air force. The freedom Quebec Premier Lucien Bouchard enjoys, along with his cohorts who would destroy this country was bought at a heavy price paid by Canadians of all kinds.

A. Gilbert Drolet
La Salle, Que.

Gambling economics

The articles on casinos were timely for those of us in British Columbia ("The curse of casinos," Cover, May 11), where the zeal of the provincial government to tap gambling knows no bounds. Is this the legacy we are passing on to our children? Our social programs are being propped up by whatever savings we can squeeze out of people. Whatever happened to the concept of government showing leadership?

Bill Lilliecrap
Chilliwack, B.C.

I still cannot understand why casino gambling is such a problem. I live in Niagara Falls and before the casino, this town was sinking faster than the Titanic. Things are booming now. In the end, I guess time will tell. Until then, let the city prosper and keep our citizens working and earning a living.

Paul K. Lemire
Niagara Falls, Ont.

Don Cherry's hockey

Don Cherry ("Is Don Cherry what's wrong with Canadian hockey?" Cover, May 18) has reduced our national sport from a game of skill, speed and finesse to bush-league hockey. We have to get back to the basic skills of the game and make it so everybody can participate, not just the Don Cherry crowd from his bush league.

Darryl Tedford
Penticton, B.C.

Don Cherry has said he will ban foreign hockey players on his Ontario Hockey League Junior A team. How different is that from the CRTC saying that all radio stations must play at least 30 per cent Canadian music? The CRTC quota is meant to help Canadian artists. Cherry is doing the same thing. He is giving hardworking Canadian hockey players a chance to play in a league that helps them towards a career in hockey.

Terry Wilson
London, Ont.

What people like about Don Cherry is he is not afraid to speak his mind. The audience is keenly aware that he is not being told what to say by the people who pay him. The CBC deserves much credit for keeping Cherry on the *Hockey Night in Canada* broadcasts.

David Laurie,
Calgary

Don Cherry hit a new low on April 11 during the Edmonton-at-Calgary game. During a break in the first-period action, he interviewed Alberta Premier Ralph Klein who was sitting in the stands. As the interview concluded and the puck dropped, a fight broke out, prompting Cherry to say that hey, there's a fight on the ice, this is great. I wondered what kind of message kids would take from that remark in an age when Canada supplies unskilled, slow-footed goons to the NHL, while Europe provides the Jaromir Jagrs, Daniel Alfredssons, Alexei Yashins, Pavel Bures, Teemu Selannes, Mats Sundins, Peter Forsbergs, etc.

Bill Marshall
Mississauga, Ont.

Maclean's
WHAT MATTERS TO CANADIANS

Editorial Update

Writers in Residence @ www.macleans.ca

Searching for some stimulating conversation? Maclean's—in partnership with Writers in Electronic Residence—now offers people an opportunity to discuss current literary or news events and issues with a diverse line up of Canada's leading writers via its website www.macleans.ca. Each month a different writer hosts Maclean's electronic literary salon, posting new pieces for discussion each week. Throughout June share thoughts with short-story writer **Andrew Pyper**, and in July compare notes with science fiction novelist **Robert J. Sawyer.**

Canada at War

For nearly a century Maclean's has published some of the finest writing on war, bringing the horrors and triumphs of the battlefield to the printed page. *Canada at War* is a critically-acclaimed collection of previously-published Maclean's articles that highlight heroic individual experiences from the First and Second World Wars through to Canadian peacekeeping efforts in Cyprus, Somalia and the former Yugoslavia. Published by Penguin Books Canada, *Canada at War* is now available in stores everywhere.

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Our Internet edition also offers:

- **Maclean's Weekly Selections** — Informative and entertaining Web sites tied to the week's top stories selected by Yahoo! Canada and Maclean's.
- **Maclean's Keepers** — A selection of previous stories organized to help readers follow current issues.
- **University Rankings** — Our annual look at universities, plus a directory with links to university Web sites.
- **Maclean's Forum** — A place to speak out on issues of the day.

Taking on the Links in Maclean's

Maclean's proudly presents Taking on the Links, an advertising supplement that will focus on the sixth annual Export 'A' Skins Game, July 26 - 28 at The Links at Crowbush Cove in Prince Edward Island. This section profiles four participating golfers: three-time Skins winner Fred Couples, 1995 British Open champion John Daly, 1998 Masters champion Mark O'Meara and the 1997 Canadian Tour Order of Merit winner Mike Weir, all battling for a total of $360,000. Watch for it in the July 13 issue of Maclean's, on newsstands July 6.

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Backstage

Anthony Wilson-Smith

Why small is not always beautiful

About 20 years ago, an aspiring journalist used to listen for hours to stories from a family friend named Tracy Ludington. Tracy was in his mid-60s then, and his best anecdotes concerned the 1940s, when he was a prominent figure in Montreal journalism. He used to recount how, after finishing his day job as city editor at *The Gazette*, he was often picked up by a limousine that took him straight to Quebec City—to begin his other job as English-language press secretary for premier Maurice Duplessis. Tracy's publisher, Charles Peters, approved, since he and the paper's owners—the Bassett family—were avid Duplessis supporters. He provided advice to Duplessis, story suggestions about him to the newspaper, and ferried messages back and forth between the premier and publisher. When Tracy told those stories, he never apologized. It was, he said, just a different time for journalists.

For which most people should give thanks. As the debate increases over the merits of Conrad Black's hold on daily newspapers in Canada, an unfortunate byproduct is nostalgia for past years and independent owners. At a discussion on print journalism in Toronto last week, John Fraser, the sometime journalist, author and full-time gadfly who was moderating, lamented the ongoing "general decline of the print industry." Similarly, John Honderich, the publisher of *The Toronto Star*, repeatedly bemoans the disappearance of other family-run newspapers.

There are many arguments in favor of regulating control of the media to avoid monopolies, but pointing to a not-so-golden past should not be among them. In the past three decades or so, journalists have become better educated and better trained: it is now almost impossible to get a job at a major media outlet without having attended university, and journalists covering beats—such as medicine or law—often have some specialized training in those fields. Reporters are better paid, and less vulnerable to the free tickets, cash and other payoffs with which they once augmented salaries. As well, many major media outlets have an ombudsperson who investigates reader complaints and alleged inaccuracies, and reports publicly on the findings. At the same time, the notion that small is beautiful in media ownership is open to question. A small, family-owned newspaper is more susceptible to the whims and pressures of local advertisers—and to those of its owners. In the first half of the century, newspaper owners routinely used their pages to further their personal interests. That was during the pre-television days, when editorials still *mattered*. Even owners committed to the public good—such as the Dennis family, longtime owners of the Halifax *Chronicle-Herald*—did not necessarily produce great products. For a long time, Haligonians joked that the paper had only two firm editorial stances: it strongly opposed drunk driving during holiday season, then opposed it again the rest of the year. An oft-cited example of independent excellence was the *Kingston Whig-Standard* in the 1980s, when then-editor Neil Reynolds (now editor of *The Ottawa Citizen*) was given a free hand by the owners, the Davies family. He once sent a reporter to Afghanistan after the invasion by the Soviet Union, although many readers complained that such efforts hid a marked decline in local coverage of more relevant, immediate local issues. Now, Reynolds has the same free hand at the Black-owned *Citizen*. The result—as *Globe and Mail* managing editor Margaret Wente accurately observed last week—is a newspaper that is "imaginative, quirky and sometimes bizarre."

> As concentration of ownership intensifies in the newspaper field, nostalgia for the good old days is often misplaced

That means that those who worry about Black's ownership, through Southam and Hollinger Inc., of 61 of the nation's 109 daily newspapers should dig deeper to bolster their case. It means discarding the argument that Black has transformed Southam into a more conservative voice by hiring new, like-minded people. The reality is that there have been few changes among publishers and editors since he took control in 1996. Despite that, *The Gazette* has acquired a much more aggressive position on English-language rights than previously under the same publisher, Michael Goldbloom, and with an editor, Alan Allnutt, who was promoted from within. The *Citizen* has been remade under a new editor, Reynolds, but has the same publisher, Russell Mills. (Two exceptions are the *Calgary Herald* and *The Edmonton Journal*, which both went outside, poaching columnists from the rival *Sun* newspapers and *Alberta Report* to give the papers a newly conservative tone more in keeping with that of Albertans—and, of course, of Black.) Southam's chief operating officer, Don Babick, is a holdover—although he chafed under the previous structure while a part of it—as is the vice-president of editorial, Gordon Fisher.

The real marvel is the—ahem—enthusiasm with which employees of the previous regime speedily and conveniently embraced the ideas and editorial vision of their new owner. Still, the remade newspapers are not only more profitable than before, but more in tune with their readership—particularly in the case of the Alberta papers and *The Gazette*, where surveys show readers overwhelmingly onside with their toughened stances on language and federalism. Perhaps that is what matters most. And is it true, as Black insists, that he does not interfere with editorial decisions? He does not have to; everyone in Southam realizes—and discusses—the career implications of falling out of favor. New circumstances bring new attitudes. It is, as Tracy Ludington would have said, a different time for journalists.

Opening Notes

Edited by TANYA DAVIES

GERARD KWIATKOWSKI FOR MACLEAN'S

Eerry, hundreds of requests from men who want the real thing

On the trail of virtual Viagra

Much to the dismay of many men, Viagra, the much-hyped potency pill from New York based Pfizer Inc., is available only in the United States and a handful of other countries. This has led thousands of desperate Canadians to cross the U.S. border for the wonder drug. But others are letting their modems do the border-hopping, scouring the Internet for the handful of ethically questionable Web sites that fill Viagra prescriptions without an in-person medical evaluation.

Marie Berry would like everyone to know that hers is *not* such a site. For the past three years, the Winnipeg pharmacist and health educator has run a Web service called the Virtual Drug Store (*www.virtualdrugstore.com*), which disseminates information about new pharmaceutical products. But since Viagra came along, Berry has received hundreds of phone calls and e-mail requests from men who have seen the site and want not information, but the real thing. "We've been getting, on average, about 40 requests *a day* to buy Viagra from us," she says. The would-be customers—who apparently do not know that Viagra is not approved for sale in Canada or that the Virtual Drugstore is not a prescription-filling service—are from as far away as Bahrain. "It's incredible,' says the soft-spoken pharmacist. "People will go to the ends of the earth to enhance their sexual performance." Or, at least, they go as far as their computer terminals.

Emporium

Number of times the National Hockey League Stanley Cup has been won by Canadian teams, according to *USA Today*: 49; by American teams: 30

Sales of the 45-cent stamp depicting the Canadian flag versus sales of the same-value stamp showing Queen Elizabeth: 4 to 1

(SOURCE: CANADA POST)

The International Federation of the Phonographic Industry reports that world sales of recorded music were $55 billion for 1997. Percentage spent in North America: 34; in the Middle East: 1

GOLDFARB POLL

The majority of Canadians say they aren't tax cheaters. But more men break the rules than women, or at least admit to doing so, and more Ontarians cheat, or admit to it, than people in other parts of the country. Percentage of Canadians who have:

	TOTAL	B.C.	PRAIRIES	ONT.	QUE.	ATLANTIC PROVS.	MALE	FEMALE
Paid cash to avoid GST	36	33	28	43	39	19	43	31
Not declared foreign-bought goods	14	20	8	21	8	6	16	12
Underpaid income tax	8	8	9	8	6	9	8	8

Data collected in February, 1997

Goldfarb Consultants Limited

DOUBLE TAKE

Flora MacDonald

In the 1970s, she was the most prominent woman in Canadian politics. And during her 16 years (1972-1988) as the MP for the Ontario riding of Kingston-and-the-Islands, Flora MacDonald's eloquence was rarely matched in Parliament. Since her defeat in the 1988 election, her profile has dimmed in Canada, but she has risen to greater prominence overseas through her work to help the downtrodden in areas of conflict. "The greatest challenge I have now is to keep my schedule straight," says MacDonald, who spends half the year away from her Ottawa home. Now 72, she says her eyes have been opened by her work for non-governmental organizations, particularly when she headed a January, 1997, Amnesty International delegation investigating the refugee crisis plaguing East Africa since the holocaust in Rwanda. "We have to find ways to help the destitute of the world," she declares.

Now and in 1976: advocate of the poor

MacDonald was a pioneer for women in the House of Commons making a failed bid for the Conservative party leadership in 1976. She also became the epitome of the Red Tory, and now boasts that her greatest political achievement came in 1979-1980 when, as external affairs minister in the short-lived Joe Clark government, she led the move to admit 100,000 Vietnamese Boat People.

Last month, MacDonald visited South America to continue her latest cause—how to alleviate the poverty of the elderly. Her ideas will be passed on to the United Nations as it prepares for 1999, the International Year of Older Persons. Still a card-carrying member of the Progressive Conservatives, MacDonald says she hopes her career might inspire young females—"women must be involved."

LUKE FISHER

A wreck rediscovered

For years, the 1914 sinking of the Empress of Ireland in the St. Lawrence River got scant attention. But now—in part, no doubt, because of the blockbuster movie *Titanic*—one of Canada's worst maritime disasters is generating a flurry of interest. The Quebec government recently declared the shipwreck a historic site. A book on the calamity, which took 1,014 lives, appeared in April. And there are plans for a $1.2 million museum to be built adjacent to the Musée de la mer in Pointe-au-Père, Que., 10 km from where the Empress sank after being hit by a Norwegian collier. "We often call it the forgotten tragedy," says Simon Cadieux, director of the museum fund-raising campaign, "because two months later there was the First World War."

The Empress of Ireland- more than 1,000 died

CP/AP/PRESS

Inevitably, the Empress prompts comparisons with the Titanic, which sank two years earlier, killing 1,522 people. There were several key differences: the Empress, owned by the Canadian Pacific Railway Co., had more lifeboats—but, because of a large hole in its side, sank faster—in 14 minutes, compared with more than two hours for the Titanic. "On the Empress people didn't have time to react," says Philippe Beaudry, a Longueuil, Que., financial adviser and founder of the Empress of Ireland Historical Society, who fought for years to get the site protected. He has made some 600 scuba dives to the wreck, collecting 500 artifacts—including silverware and a heavy brass bell from the mast. His own finds will be on display this month at the L'Islet-sur-Mer museum near Quebec City. The Empress is finally getting royal treatment.

Capital Confidential

Bernard Shapiro, principal of Montreal's McGill University, was not surprised that there was an outcry when he accompanied Lucien Bouchard on the Quebec premier's four-city swing through the United States last month. Just at the extent of it. Shapiro's office is still trying to cope with the 200 or so letters and phone calls flowing in from anglophone Montrealers about the trip. Many have been supportive, he says. But a good number have been "quite abusive," calling for his resignation. McGill psychology associate professor Don Donderi, has even publicly excoriated his boss for "selling out the university to a separatist premier."

The sharp reaction may stem partly from the fact that Shapiro was the only non-governmental member of the tour invited to accompany Bouchard to the daily press conferences—an image seen in Montreal on the nightly news. In any case, Shapiro says he would do it all again, both for the business contacts he made as well as for the opportunity to have four days of quality face time with Bouchard to make the case for the future of Quebec's top universities. As it happens, Shapiro's wife, Phyllis, an education professor at McGill, has become lunch chums with Audrey Best, Bouchard's wife, who just completed first-year law at McGill. As for his detractors, Shapiro says: "There are people who can cope with reality and people who can't. We just have different views of who fits in what category."

BEST-SELLERS

FICTION

1. **A Widow for One Year,** *John Irving (1)*
2. **Cities of the Plain,** *Cormac McCarthy (8)*
3. **The Street Lawyer** *John Grisham (5)*
4. **Larry's Party** *Carol Shields (6)*
5. **Girlfriend in a Coma,** *Douglas Coupland (3)*
6. **Ghost Country** *Sara Paretsky*
7. **Barney's Version** *Mordecai Richler (4)*
8. **Damascus Gate,** *Robert Stone (3)*
9. **Black and Blue,** *Anne Quindlen (2)*
10. **Pandora** *Anne Rice (7)*

NONFICTION

1. **Understanding Men's Passages,** *Gail Sheehy (3)*
2. **Angela's Ashes,** *Frank McCourt (2)*
3. **The Gifts of the Jews,** *Thomas Cahill (1)*
4. **Titan: The Life of John D. Rockefeller Sr.,** *Ron Chernow (4)*
5. **Simple Abundance,** *Sarah Ban Breathnach (7)*
6. **The Cult of Impotence,** *Linda McQuaig (5)*
7. **The Man Who Listens to Horses,** *Monty Roberts (6)*
8. **Who Killed Canadian History?,** *Jack Granatstein (6)*
9. **The Millionaire Next Door** *Thomas Stanley and William Danko (9)*
10. **A Walk in the Woods,** *Bill Bryson (10)*

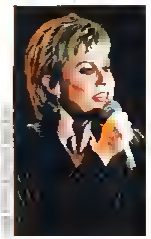
( ) Position last week. Compiled by Brian Bethune

A man and his Arrow

The mastermind behind Canada's 1950s Avro Arrow project, Crawford Gordon has been called both a genius and a schemer. Author Greig Stewart uses archival material and interviews with colleagues and friends to reveal the man behind the plane in *Arrow Through the Heart, the Life and Times of Crawford Gordon and the Avro Arrow.*

Passages

SEPARATING: Singer **Anne Murray,** 53, and her husband, **Bill Langstroth,** 68, in Thornhill, Ont. Murray and Langstroth, a former television producer with the CBC, were married in 1975, and Langstroth has kept a low profile since. Murray, best known for her hits *Snowbird* and *Danny's Song*, will remain in the family home north of Toronto with their two sons, 21 and 19.



DIED: **David Foster,** 82, owner of the 1983 Kentucky Derby winner **Sunny's Halo,** in Toronto, after a long illness. Sunny's Halo was one of only two Canadian-bred horses to win the Derby.

AWARDED: The 1998 Benjamin Franklin Award for best children's book in the United States, to Canadians **Susan V. Bosak,** 35, and **Laune McGaw,** 45, for *Something to Remember Me By*, in Chicago.

AWARDED: The Canadian Journalism Foundation's Lifetime Achievement Award, to *Maclean's* columnist **Peter C. Newman,** 69, in Toronto. *The Toronto Star* won the Excellence in Journalism Award.

NANED: University of Toronto criminology professor **Clifford Shearing,** 56, to the commission on policing in Northern Ireland, in Belfast. The eight-member commission is headed by **Chris Patten,** former British governor of Hong Kong.

RETIRING: Former downhill ski champion **Kate Pace Lindsay,** 29, in Toronto. Pace Lindsay represented Canada at two Olympic Games, and was ranked number 1 in the world in 1993.

DIED: Country music singer **Helen Carter,** 70, in Nashville, Tenn. Carter was a member of the country group the Carter Family in the 1940s.

DIED: Broadway legend **Dorothy Stickney,** 101, in Manhattan. Stickney's career spanned five decades and included a role in the play *Life With Father*, the longest-running nonmusical in Broadway history.

DIED: Former mayor **Sam Yorty,** 88, at his home in Los Angeles. Yorty presided over the city from 1961 to 1973, a tumultuous time that included the 1965 Watts riots.

The Health Report

COVER

The statistics reveal uneven levels of care

BY ROBERT MARSHALL

Where do Canadians live the longest and healthiest lives? Which provinces have the most hospital beds, doctors and nurses, or spend the most on health care? Those are some of the findings in the inaugural *Maclean's* Health Report, presenting the best available indicators of the state of health-care delivery, province by province. Altogether, they provide a fascinating inside view of health care in Canada—and the major differences among the provinces. Some highlights:

- Westerners are generally in better health and will live longer than Atlantic Canadians. Why? The answer may have as much to do with social conditions and lifestyle choices as with the standard of medical care.
- Across Canada, the numbers of hospital beds, nurses and, in some areas, doctors are diminishing. The latest per capita numbers show Saskatchewan left with the most beds, Prince Edward Island with the least, New Brunswick with the most nurses, Ontario with the least, the Yukon with the most general and family practitioners, Prince Edward Island again with the least, and Quebec with the most specialists, the Northwest Territories with the least.
- British Columbia leads the provinces in health-care spending per capita. Newfoundland is at the other extreme.
- Rates at which medical conditions occur, procedures used to treat them, and the availability of the latest high-tech medical equipment vary—sometimes widely—from province to province.
- Hospitals acknowledge that what they call "misadventures" do happen, but analysts say the rates of accidental injury are actually much higher than the incidents reported.
- Visits to hospital emergency departments have decreased since the late 1980s, while use of other hospital outpatient facilities has increased.
- Newfoundland has the highest incidence of overweight people in its population, Quebec and British Columbia have the lowest.

The *Maclean's* Health Report appears at a time when Canadians are anguishing over a medicare system they proudly regard as a fundamental characteristic of their country. Their positive attitude is well placed. Canada ranks among the world leaders in the critical measurements of longevity, infant mortality and freedom from preventable disease. Given that accomplishment, criticism may seem to be carping. But the fact is, Canadians do not get enough information about how well their health care dollars are being spent.

Is it too much, for instance, to expect a system that sucked $76.6 billion out of the country's treasuries last year in the name of health care to show exactly how many people died in its hospitals? Apparently so, because death statistics are complicated by the fact that some hospitals count DOAs (patients dead on arrival), and some don't. "Information-gathering is improving," says Michael Decter, chairman of the Canadian Institute for Health Information, an Ottawa-based independent health data agency, and *Maclean's* partner in preparing the Health Report. "I think CIHI and Statistics Canada are making ground. But it is astonishing how much more information for the consumer is available in the United States, some of it mandated by state laws."

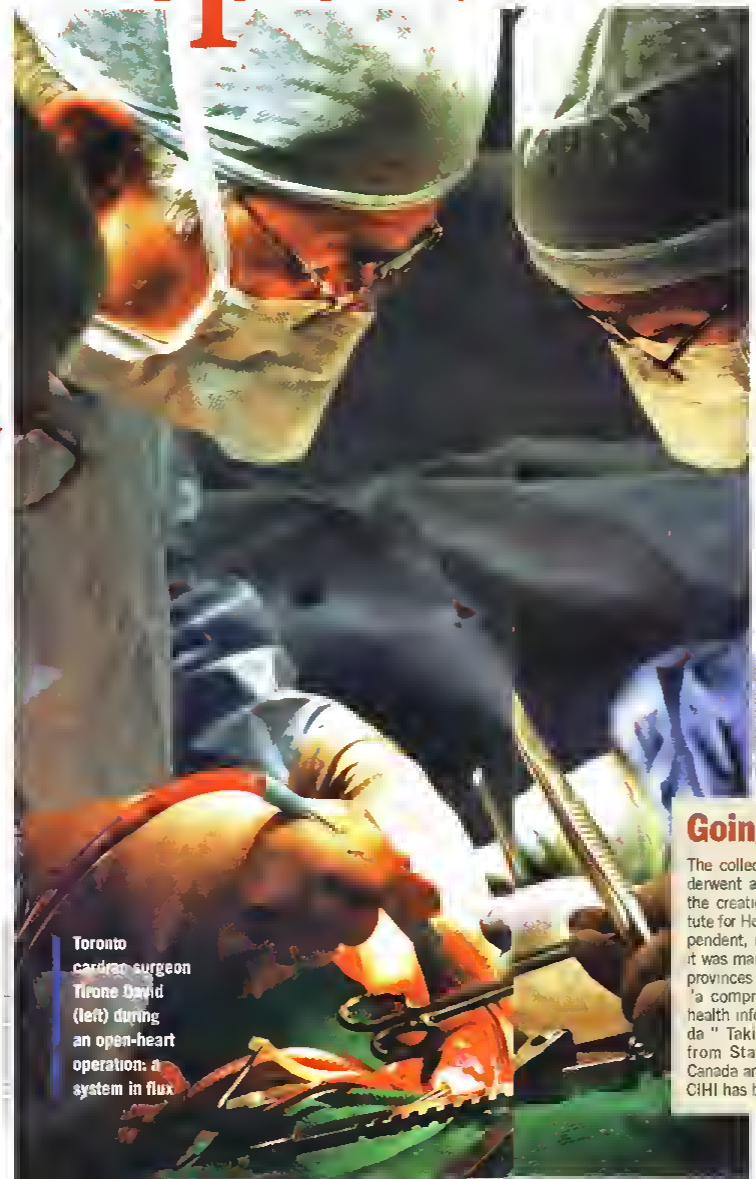
Gordon Lever's experience is one indicator of the need for more openness in Canada's health system. The Kingston, Ont., resident has helped found a patients' right organization since the death of his 49-year-old wife last year, just a month after being diagnosed with stomach cancer. "From the family doctor to the test centre to the hospital there was a litany of errors," says Lever. When he tried to get his wife's medical record after her death, "the hospital told me I wasn't entitled to it," he says.

Canadians are confused. The same governments that squeezed health-care spending in the name of fiscal prudence and the need to "restructure" are suddenly throwing money into the system. Alberta did it. Ontario did it. And last week, Quebec put $110 million back into this year's health-care budget—as the province's 7,200 GPs, complaining of low pay, threatened to withdraw services for at least four days starting this week. Meanwhile, even as many experts say funding is not the problem, federal Health Minister Allan Rock says he is counting on more money for home care and other programs in the next federal budget.

Is the system suffering because governments made their cuts too hastily? Any attempts to address questions like that on a community level are frustrated by a myriad of problems: confidentiality and privacy legislation, inconsistent measuring formats, differing functions of hospitals. Even the phrase "health care system" is a misnomer, Decter says, because it is made up of independent sectors operating with little co-ordination. No one agency is monitoring the operations of all Canadian hospitals, or even comparing the care provided by major communities. Only at the provincial and territorial level have strides been made in reporting information in a consistent way, taking account of changes over time.

Maclean's worked closely with CIHI to define the issues and gather the material that appears in this Canada-wide report. Other organizations have published in-depth surveys of some aspects of the system—Statistics Canada, for instance, periodically reviews such issues as the distances people travel in various parts of the country to see a physician. And within some provinces, information gathering is much more advanced than it is on the national level. The Institute for Clinical Evaluative Sciences in Toronto has produced two exhaustive studies of practices and outcomes at all Ontario hospitals. And other reports are expected this year, including a province-wide comparison from the Ontario Hospital Association and another from the University of Toronto on patient satisfaction at the city's teaching hospitals.

The computer revolution has made information management much more efficient. "It is only now that technology is getting cheap enough that we can measure the indicators of health care delivery," says Decter. "Until now, we've been saying 'Sure, there's a wait in emergency, but how bad is it? No one knows.' " But are health authorities across Canada devoting enough of their budgets to providing the answers that patients—and potential patients—want to have? "We don't know," says Decter, "because we don't collect that information."



Toronto cardiac surgeon Tirone David (left) during an open-heart operation: a system in flux

Emergencies and outpatients

Fewer patients are going to emergency departments, and the total using all so-called ambulatory-care services is up only marginally from 1986-1987 levels

	Visits in millions 1986-1987	Visits in millions 1995-1996*	% change '86-'87 to '95-'96
Outpatient medical services, day or night	1.8	3.05	+69.4
Outpatient surgical services, day or night	1.33	1.78	+33.8
Outpatient clinics	14.3	15.52	+8.5
Emergency	15.82	13.1	-17.2
Total visits	33.2	33.43	+0.7

* Preliminary estimates

SOURCES: STATISTICS CANADA (1986-1987) AND CANADIAN INSTITUTE FOR HEALTH INFORMATION (1995-1996)

Going straight to the source

The collection of medical data underwent a revolution in 1993 with the creation of the Canadian Institute for Health Information. An independent, nonprofit national agency, it was mandated by Ottawa and the provinces to develop and maintain "a comprehensive and integrated health information system for Canada." Taking over some programs from Statistics Canada, Health Canada and some smaller agencies, CIHI has become the country's principal source of official health information. StatsCan still provides some health-related data, and specialized information comes from other agencies such as the Canadian Co-ordinating Office for Health Technology Assessment.

Much of the information in this package is drawn from CIHI's Discharge Abstract Database, which holds data as recent as 1996-1997. It records the procedures performed on more than 85 per cent of patients discharged from or who died in Canada's hospitals. The biggest missing element is Quebec, where only a handful of small institutions submit data to DAD. Similarly, roughly 60 per cent of hospitalizations in Manitoba, 20 per cent in Prince Edward Island, and one per cent in Saskatchewan are not captured there.

Information for most of the full national comparisons comes from the National Morbidity database maintained jointly by CIHI and Statistics Canada. Its most recent data is from the fiscal year 1995-1996.

The high cost of healing

It's not how much, but *where* it's spent that counts most

BY WARREN CARAGATA

Despite how it may seem some days as the public tunes into the debate over health-care funding, governments in Canada have not turned off the tap. Canadians spent an estimated $76.6 billion on health care in 1997, up from $75.5 billion a year earlier, and, says Toronto health-care consultant Michael Decter, chairman of the Canadian Institute for Health Information, "I don't think there's a case that the overall system is underfunded." What has happened is that, in the name of fiscal prudence, the controls on the funding tap have become much tighter. What was once an annual flood of new money has been reduced to a yearly trickle of extra dollars. The once-rampant growth in health-care spending has ended. In the dry language of a 1997 report from CIHI, "Health expenditure growth remains virtually flat."

Beyond the question of how much money overall is being spent, the three key issues in the debate are the amount that the federal government contributes, the diminished size of the annual budget increases, and, critically, *how* the money is spent. These are the areas where the revolution in Canadian health care is taking place.

The amount of federal money in the system is at the heart of an often bitter federal-provincial war of words. Even the experts at the Canadian Institute for Health Information, the independent agency charged with gathering and distributing health data, find that figure difficult to determine. In 1996, the federal government changed the way it finances health care, combining contributions for health, welfare and postsecondary education into a single fund, the Canadian Health and Social Transfer. As a result, comparisons between the CHST and earlier levels of federal contributions are perilous and inexact.

But by the federal government's own accounting, the cash flowing to the provinces from the new program was to fall from $14.9 billion in 1996-1997 to $12.5 billion in the current fiscal year. Ottawa now covers just 21.5 per cent of provincial government health expenditures, compared with 24.1 per cent in 1990 and 30.6 per cent in 1980. "There has been a major shift in the way in which health care has been funded," Saskatchewan Health Minister Clay Serby told *Maclean's*. Serby, who this year chairs the national conference of health ministers, said as Ottawa has reduced its share, the provinces have been left to pick up the slack, particularly for new programs such as home care and for the costs of drugs, a rapidly increasing area of health spending. CIHI figures indicate provincial and territorial government spending rose from $42.1 billion in 1990 to $48.6 billion last year. Only in Alberta did spending actually drop—by a shade—to $4.01 billion from $4.08 billion. Among the provinces, spending in British Columbia rose the most dramatically over the seven years, an increase of $2.1 billion or 43.2 per cent. In addition, the provinces as a rule have been devoting a slightly larger share of their total budgets to health care—32.5 per cent in 1996, up from 32.3 per cent in 1990. Ontario had the highest ratio among the provinces in 1996, spending 36.7 per cent of its total budget on health, while Quebec had the lowest at 29 per cent.

But provinces, too, have been wrestling with budget deficits, which has generally meant much less generous increases than were once the case. In fact, much of the rise in provincial spending came early in this decade with increases of more than eight per cent in both 1990 and 1991. From 1994 to 1997, spending by the provinces crept up on average by only 0.02 per cent annually. That is a big downshift from the 1980s, when health administrators could look forward to average annual increases of 10.6 per cent.

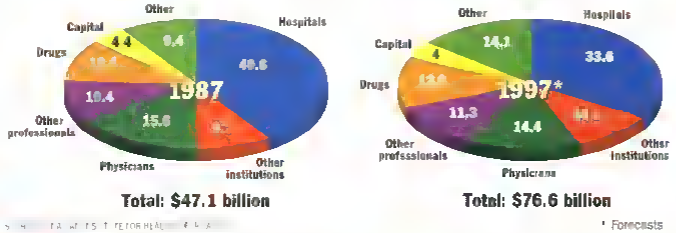
Paradoxically, says Richard Plain, a University of Alberta health-care economist, tighter budget control may have saved medicare by making it more affordable. As the '90s began, many observers were wondering how long the country could maintain a system that was gobbling up an ever-larger share of resources. By 1992, health spending had reached 10.2 per cent of total economic output—second only to the Americans, and few of them were ready to hold their system up as a model. By 1995, Canada's health spending had slipped to 9.6 per cent of gross domestic product—trailing not only the Americans but the Germans and French as well.

The widespread public perception that health budgets have been slashed substantially may have grown out of the publicity surrounding hospital closures. One vivid symbol of the change: the Bow Valley Centre in Calgary, formerly Calgary General, a venerable 600-bed facility shut down last year. It now sits empty, awaiting demolition. The public, Decter says, has defined health care by the hospitals in their community. "Closing a hospital is about the toughest thing anyone can do politically," he says, "because it is such a symbol."

Nationally, funding for hospitals as a proportion of total health spending dropped from 40.6 per cent in 1987 to an estimated 33.6 per cent in 1997. In Alberta over three years, says Plain, "we wiped out 40 per cent of the acute care hospital beds." And although the primary drive to close beds may often have come from finance ministers rather than their colleagues in health, many hospitals and wards were sitting targets. "In Canada," says Serby, "we had too many hospitals and too many hospital beds." In 1994,

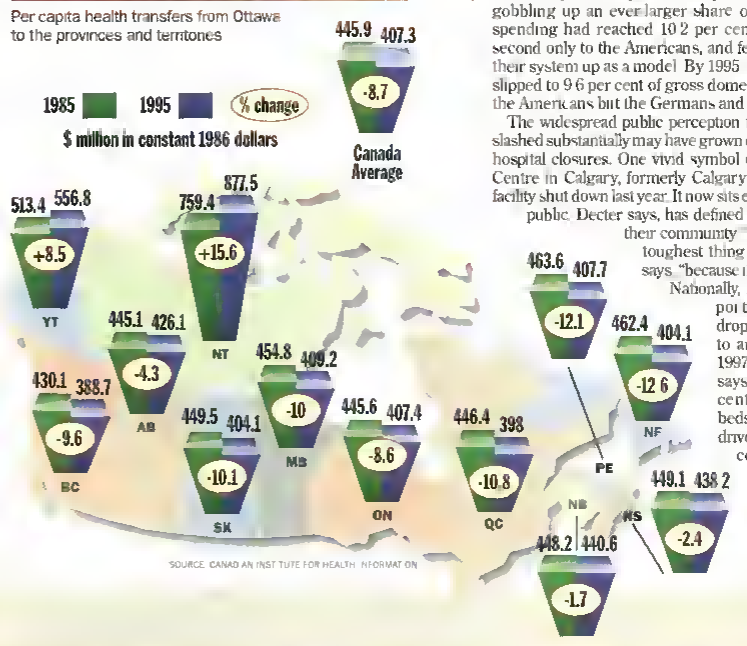
Shifting the focus away from hospitals

Percentage of total health-care spending in Canada based on actual dollars



Ottawa's shrinking role

Per capita health transfers from Ottawa to the provinces and territories



Where the money goes

Overall health-care spending, provincially and nationally, and spending on the big-three categories of health budgets. Totals include smaller categories not covered in this table. The territories are unranked because of costs associated with large areas and small populations. **Figures are in actual dollars, per capita.**

	Newfoundland		Nova Scotia		P.E.I.		New Brunswick		Quebec		Ontario		Manitoba		Saskatchewan		Alberta		British Columbia		Yukon Territory		Northwest Territories		Canada	
	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994
Hospitals	$576.94	989.39	640.84	962.95	512.16	899.27	588.76	977.67	659.10	976.18	569.61	894.1	595.77	908.18	525.96	732.65	652.07	869.71	550.14	879.77	624.71	1,050.59	911.93	2,056.48	001.21	914.62
Physicians	130.05	238.37	152.20	278.38	141.43	239.49	154.79	278.84	184.11	305.38	242.84	433.	172.29	260.17	167.22	290.20	218.50	337.27	290.68	422.65	209.12	339.61	189.85	321.03	215.00	365.50
Drugs	214.48	302.11	139.21	338.57	251.38	361.56	155.12	320.54	109.02	302.32	136.33	348.1	138.22	261.00	109.75	275.24	116.64	264.03	130.73	263.35	131.53	224.73	164.29	330.16	128.82	310.33
Total	1,292.00	2,162.77	1,282.74	2,266.86	1,348.56	2,339.59	1,348.05	2,344.34	1,386.32	2,359.32	1,424.56	2,605.1	1,482.21	2,571.68	1,371.63	2,355.25	1,594.85	2,399.20	1,511.52	2,640.50	1,569.89	3,176.33	2,367.12	5,463.82	1,432.58	2,499.19
Ranking	9	10	10	9	7	8	8	7	5	5	4	2	3	3	6	6	1	4	2	1						

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Shifting the burden

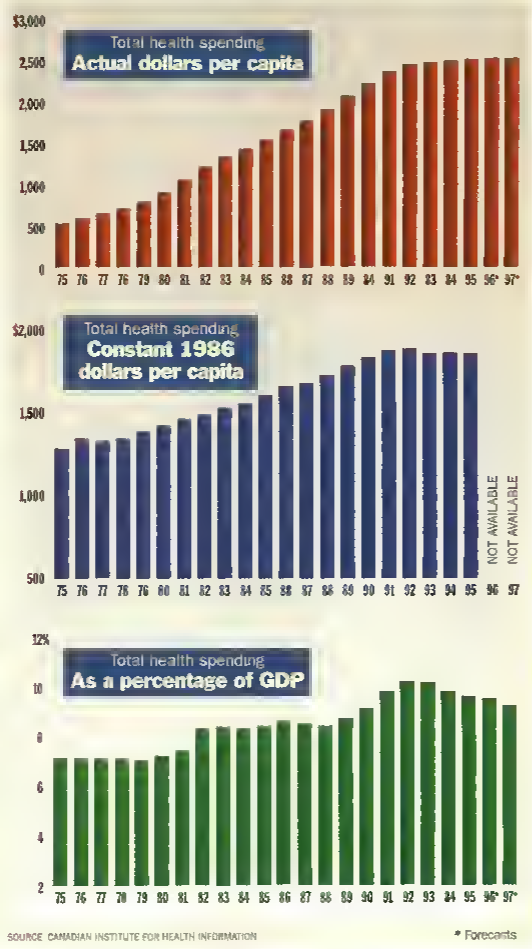
Ottawa's health transfer payments to the provinces as a percentage of total health spending by each provincial government

	1985	1995	% change
NF	32.7	24.8	-24.2
NS	31.5	24	-23.8
PE	31.5	23.6	-25.1
NB	30.7	22.8	-25.7
QC	29.5	22.9	-22.4
ON	27.1	20.4	-24.7
MB	27.4	20.3	-25.9
SK	28.8	22.4	-22.2
AB	24.3	23	-5.3
BC	27	20.1	-25.6
YT	30.7	18.6	-39.4
NT	29.6	19.3	-34.8

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

What's up, Doc?

Different measures of health-care spending show different recent trends



SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

* Forecasts

Canada was spending a greater percentage of its health budget on inpatient hospital care than any other Group of Seven nation except Italy.

The bandwagon for balanced budgets was joined by governments of all stripes and with health costs spiralling, there was already widespread agreement that some form of health-care reform was overdue. "Everyone knew that they had to make some changes to the system," says Decter, "but that really didn't happen until there was the financial issue to compel them."

When reform came, many people found the revolution too abrupt—and frequently it was, says Decter. Too often, he believes, "we did it backwards"—closing hospital beds before alternatives were available in the community. There is agreement among the experts that some money has to be put back into the system to fill in some of the cracks left by a relatively abrupt change. The public, too, after generally endorsing cuts made in the name of deficit reduction, seems to support the idea of spending more money on health care. In Ontario, the Conservative government has started moving in that direction, giving extra money to hospitals to relieve the pressure on emergency services, and increasing spending on nursing homes, homes for the aged and home care. Health care was an issue in the Nova Scotia election, where the Liberals were returned with a scant minority, and in the New Brunswick Liberal leadership contest in which Camille Thériault became premier. At the federal level, the Liberals have raised the floor for cash transfers to the provinces to $12.5 billion from $11 billion, making good on a promise from last year's election.

Even so, many experts insist that the amount of funding for health care is adequate. And the changes do not pose a threat to the health of Canadians. "I don't think there's any evidence to show that the health status of Canadians has been diminished as a result of the cuts," says Plain. Dr. John Millar, who as provincial health officer advises the B.C. government on health matters, agrees. "There's enough money in the health-care system," says Millar. "What's needed is to better manage it." But perception, as always, depends on your point of view. "If you're Mr. Jones and you're lying in a stretcher in a hallway at a hospital," says Decter, "then it is a crisis for you." The final verdict on Canada's unfolding revolution in health care may not be on whether change was needed, but how well it has been managed.

A staffing crunch looms

It is difficult to imagine how things could get any worse—but they likely will. In Canada today, nurses are struggling under the burden of staff cuts and hospital policies that demand they work longer hours while caring for more and sicker patients. It is taking its toll: a recent survey showed that about 40 per cent of Quebec nurses suffer from severe stress and are ready to quit. Doctors, too, are frustrated by exhausting workloads, and other problems such as poor access to diagnostic equipment. They also see their colleagues reaping much greater financial rewards in the United States. As a result, some are fleeing the country—a net loss of 513 active physicians in 1996. Although that is less than one per cent of the total physician base, it is up fully 130 per cent from 1991. Add to that mix the increasing medical needs of an aging baby boomer population and what emerges is a formula to totally overwhelm the system. "I hope I don't get sick in 20 years," says Danielle Frechette, 40, a researcher for the Ottawa-based Royal College of Physicians and Surgeons of Canada, "because I don't know who's going to be around then to treat me."

There are no simple solutions. What is clear is that the system's human resources—principally the general practitioners, family practitioners, specialists and registered nurses—are demanding to be heard in the midst of wholesale health care restructuring by the provinces. A case in point is Ontario. Over the past 10 years, it has slipped from fourth to last place among provinces and territories in terms of per capita numbers of working RNs. Doris Grinspun, executive director of the Registered Nurses Association of Ontario, says many RNs have been replaced by lower-paid registered practical nurses and personal-care support workers with less training. But what Ontario failed to realize, says Grinspun, is that downgrading creates hidden costs. "The lower the education and skill level of the health-care provider," she says, "the higher the level of supervision required—more charge nurses, more nurse managers. And that's big money."

The provinces, meanwhile, have concerns of their own. Financially sound Alberta ranks only ninth in the number of GPs and FPs, sixth in specialists and ninth in RNs. But Garth Norris, director of communications for Alberta Health, cautions against drawing conclusions based solely on those numbers. "We're not particularly interested in per capita comparisons with other provinces," Norris says. "Our concern is whether we have the right amount of physicians and the right number of nurses in the right places."

That said, Canada overall ranks a poor 20th among 28 members of the Organization for Economic Co-operation and Development in terms of per capita doctors. Furthermore, Dr. Victor Dirnfeld, president of the Canadian Medical Association, worries that a decision to reduce medical school enrolment in 1994, and less willingness among new doctors to sacrifice family time to work long hours, also conspire to undermine the system's ability to meet patients' needs. "The impact on health care hasn't been too bad so far," says Dirnfeld, "because those who remain to deliver the service work longer and harder." But even the most dedicated health-care workers eventually reach their limit.

DANYLO HAWALESHKA

Levels of service

The numbers of general and family physicians, specialists and registered nurses per 1,000 population have shifted over a decade (ranking in red)

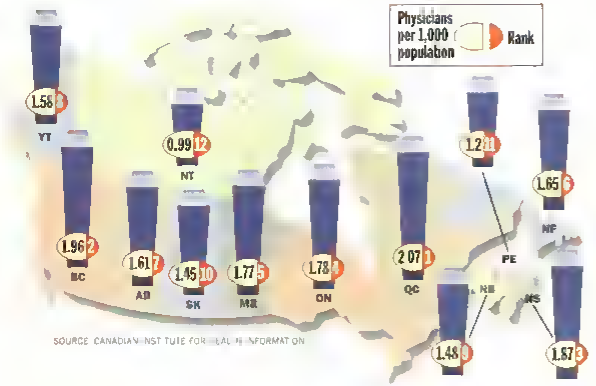
	GPs/FPs		Specialists		RNs	
	1987	1997	1987	1997	1987	1997
NF	1.02 2	1.01 4	0.49 10	0.64 7	7.46 3	9.2 4
NS	1 4	0.98 5	0.8 4*	0.89 3*	9.26 1	9.06 5
PE	0.86 9*	0.69 12	0.54 7	0.51 10	8.33 3	9.35 2
NB	0.7 11	0.86 7*	0.52 9*	0.82 9	8.62 2	9.9† 1
QC	0.95 5	1.02 3	0.97 1	1.05 1	7.75 8	7.98 9
ON	0.91 9	0.86 7*	0.9 2*	0.92 2	8.06 4*	6.89 12
MB	0.89 9	0.88 9	0.8 4*	0.89 3*	9 6*	9.22 3
SK	0.9 7	0.89 9*	0.52 8*	0.59 9	8.08 4*	8.29 9
AB	0.86 9*	0.85 9*	0.7 6	0.76 8	8 6*	7.63 9
BC	1.01 3	1.08 2	0.9 2*	0.88 5	7.19 10	7.46 10
YT	1.03 1	1.36 1	0.19 11	0.22 11	5.95 11	9 7
NT	0.66 12	0.79 11	0.18 12	0.21 12	5.35 12	7.12 11
Canada	0.93	0.93	0.85	0.9	7.97	7.59

*Ties †Preliminary estimates

SOURCES: CANADIAN INSTITUTE FOR HEALTH INFORMATION and STATISTICS CANADA

Where the doctors work

Number of physicians, including specialists, 1997



When hospitals lose beds

Next to overflowing emergency wards, one of the most obvious—and upsetting—signs of health-care reform for many Canadians has been the unavailability of hospital beds when they are needed. Since the mid-1980s, provincial and territorial governments have closed wards and hospitals—and the beds they housed. The net result was nearly ten-per-cent fewer hospital and residential care beds in Canada by 1996 than in 1987. To cushion the blow, health-care reform was aimed at realigning how beds are used. The reform program has included shortening hospital stays for new mothers, postoperative patients and others providing more procedures on an outpatient basis or in community clinics, and increasing the number of long-term-care beds so those who are not acutely ill are not clogging up acute-care beds. It is all part of the health ministers' mantra of "community care."

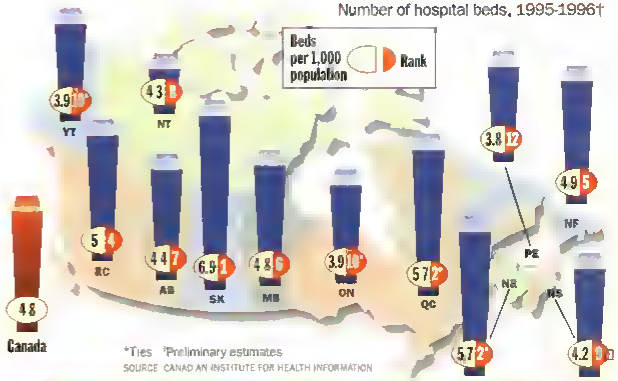
There was just one problem—and it was the ultimate catch-22. To save money in hospitals, longer-term patients had to be moved into community programs. But in some cases there was no money for community-care programs until funds could be saved from closing hospital beds. "We couldn't run two systems simultaneously," says Dr. Dan Reid, a health ministry adviser in Nova Scotia. For provinces with neither the foresight nor the deep pockets to provide transitional funding, the decision had to be: cut hospital beds first, add community programs later. "There were some terrible growing pains," says Reid, "but the worst is behind us now." He notes that Nova Scotia's home-care budget has grown to $70 million this year, up from $18 million just three years ago.

Still, not everyone is convinced that a wholesale shift away from hospital care will save a lot of money. "There are economies of scale in hospitals," says Wayne Taylor, a business professor at McMaster University in Hamilton who specializes in health service management. "There is not enough research, so we don't know if we are creating dis-economies with community care." In the health-care business these days, "bed" is not a relaxing word.

BARBARA WICKENS

A bed to lie in

Number of hospital beds, 1995-1996†



Bricks, mortar and high-tech scanners

Total health care spending on construction and equipment

	Capital spending (actual $ per capita)	% change	Total spending (actual $ per capita)	Capital spending as % of total spending
1977	$23.70		$651.44	3.6
1987	77.53	+227.13	1,772.42	4.4
1997*	100.51	+29.64	2,528.47	4

*Forecast

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Musical beds

The change in numbers of hospital* and residential-care† beds since 1986-1987

	Hospital			Residential		
	1986-1987	1995-1996**	% change	1986-1987	1993-1994	% change
NF	3,636	2,812	-22.7	4,160	4,309	+3.6
NS	5,947	3,981	-33.1	9,048	9,421	+4.1
PE	767	515	-32.9	1,774	2,179	+22.8
NB	5,161	4,364	-15.4	7,096	8,382	+18.1
QC	56,264	42,397	-24.6	48,249	40,891	-15.3
ON	52,151	44,129	-15.4	92,361	88,741	-3.9
MB	6,560	5,461	-16.8	12,989	12,861	-1
SK	7,616	7,063	-7	11,833	11,568	-2.2
AB††	18,393	12,267	-33.3	23,519	28,054	+19.3
BC	21,098	19,233	-8.8	25,900	26,933	+4
YT	154	122	-20.8	237	169	-28.7
NT	390	288	-26.2	162	339	+109.3
Canada	178,137	142,652	-19.9	237,328	233,847	-1.5

*Includes general, pediatric, psychiatric and rehabilitation
†Includes facilities for the aged, physically disabled, developmentally delayed, emotionally disturbed children, alcohol and drug addicted, delinquent and transient. Figures unavailable since 1993-1994
**Preliminary estimates
††Some of shift to residential reflects a 1990 change in reporting practices

SOURCES: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Scanners and blasters

As director of the positron tomography program at the Hamilton Health Sciences Corp in Ontario Dr Claude Nahmias is in an unusual position—he oversees the operations of *two* positron emission tomography (PET) scanners "That's almost one-third of the machines in Canada," says Nahmias, who believes, as do many other radiologists, that the diagnostic imaging technology—which shows levels of chemical activity in body tissues—deserves to be much more widespread Moreover because many physicians think the Hamilton machines, like the others in Vancouver, Toronto, Ottawa and Montreal, are used predominantly for research, they do not refer patients as often as they might But the Hamilton PET scanners are used mainly for clinical purposes, says Nahmias The wait is usually less than two weeks, compared with six to nine months for non-emergency access to another high tech diagnostic tool, magnetic resonance imaging (MRI) Says Nahmias "We have a very well kept secret"

Word, and use, of the technology may well spread just as it has for MRIs and computerized tomography (CT) scanners before it In the early 1970s, CT scanners—also known as CAT scanners—were considered a rare research tool Unlike conventional X-rays, which are best at revealing bone and lung tissue, CT scanners were hailed as a great advance for their ability to show detail in soft tissue Now CT scanners can be found in virtually every 200-plus-bed hospital in Canada, and new uses are still being uncovered In January for instance *The New England Journal of Medicine* reported that the CT scanner is the diagnostic tool of choice for appendicitis, an otherwise notoriously difficult diagnosis

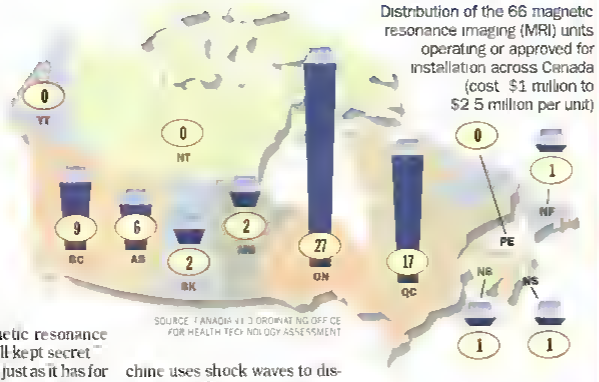
Not all high-tech, big-ticket equipment becomes more popular with time One example is the lithotriptor That million-dollar machine uses shock waves to disintegrate kidney and ureteral stones, which patients can then eliminate in their urine There are now 12 in Canada and that may be enough to handle the number of cases each year Unlike diagnostic equipment, which comes under new demand as new applications are discovered, the lithotriptor is "a very limited device," says Dr Allen Rowley, a co-director of the lithotripsy unit at Vancouver General Hospital It does its job well but it does only one job Patients can now use the machines on an emergency basis within a few days Any decisions to add more, Rowley says, would be based on how far patients must travel for treatment

The MRI, still not as widespread as the CT scanner, shows even more detail in soft tissues Particularly useful for studying the brain and spinal cord It is unmatched in diagnosing multiple sclerosis On the grounds that better diagnosis can prevent unnecessary surgeries—and save money—some provinces are on a buying spree Ontario is increasing its MRIs, to 35 by the year 2000—a decision prompted by a 1994 report from the Ontario Association of Radiologists Among other things, it noted that Canada ranked far behind world leaders Japan and the United States and about equal to Turkey, in MRIs per capita. The association is now preparing a paper in support of PET scans Nahmias's "well kept secret" may yet get out.

BARBARA WICKENS

State-of-the-art imaging

Distribution of the 66 magnetic resonance imaging (MRI) units operating or approved for installation across Canada (cost $1 million to $2.5 million per unit)



SOURCE CANADIAN CO-ORDINATING OFFICE FOR HEALTH TECHNOLOGY ASSESSMENT

Deep-pockets medicine

Who has the expensive equipment?
(units per million population in brackets)

	CT scanners	PET scanners	Lithotriptors
Typical cost per unit	$350,000 to $1.5 million	$1 million to $2.5 million	$500,000 to $1.5 million
NF	6 (10.5)	0	1 (1.7)
NS	9 (9.5)	0	1 (1.1)
PE	1 (7.3)	0	0
NB	8 (10.5)	0	1 (1.3)
QC	68 (9.2)	2* (0.27)	3 (0.4)
ON	84 (7.4)	4 (0.35)	3 (0.3)
MB	10 (8.8)	0	1 (0.9)
SK	7 (6.8)	0	1 (1)
AB	23 (8.2)	0	2 (0.7)
BC	28 (7.1)	1 (0.25)	1 (0.3)
Total	244 (8.1)	7 (0.2)	14 (0.5)

*Excludes one used exclusively on animals

SOURCES: CANADIAN CO-ORDINATING OFFICE FOR HEALTH TECHNOLOGY ASSESSMENT AND PROVINCIAL HEALTH MINISTRIES

Computerized tomography (CT) scanner
Uses computer and X-rays to produce cross-sectional images to aid in diagnosis of conditions including cancer, strokes and head injuries

Positron emission tomography (PET) scanner
Uses radiation-emitting substances with computers to produce cross-sectional images of cell activity to investigate tumors, epileptic activity, brain function, the heart and other organs

Extracorporeal shock-wave lithotripter
Uses shock waves to break up stones in kidney or ureter, allowing patient to excrete fragments in urine

Why people go to hospitals

Read as an indicator of health problems, statistics that track reasons for hospitalization generally set off warning signals in the Atlantic provinces. Their hospitalizations for respiratory problems, heart and stroke conditions, and tumors of all kinds are the highest in the country. New Brunswick, particularly, stands out with the highest rates in eight categories, including digestive disorders, heart disease and heart attack, nervous system disorders, tumors, and respiratory conditions such as asthma and bronchitis. The main reason seems to be lifestyle choices. "A lot of people here are overweight—and New Brunswickers smoke like mad," says Dr. James Parrott, head of cardiac surgery at the provincial Heart Centre in Saint John.

By and large, Canadians seem to be healthier the farther west they live, with British Columbia and Alberta reporting the lowest rates of hospitalization for malignant and benign tumors. B.C. and Manitoba hospitalizations for heart and stroke conditions are among the nation's lowest. An exception in the West is Saskatchewan, where hospital rates for many illnesses resemble levels in the Atlantic region.

Some statistics may be skewed because Canadians in remote or poorer regions often seek treatment in other provinces—most Prince Edward Island residents needing cardiac surgery go elsewhere. (In charts on this and the following page, figures for Yukon and Northwest Territories residents—who frequently travel south for medical treatment—are included in the national rates.) Other factors can alter the numbers. Although Prince Edward Island reports the most admissions for mental disorders, authorities say that may simply reflect the island's relatively large number of beds for treating alcoholism and drug addiction. As for Newfoundland showing the least admissions for mental disorders, experts attribute that to its traditionally strong community and family networks.

MARK NICHOLS

Reasons for hospitalization

The rate of occurrence of health problems that send people to acute-, convalescent- and chronic-care facilities varies slightly from province to province. The chart shows rates of hospitalization per 10,000 population in 1995-1996 for specific broad categories, in numerical order nationally, and provincial rates, with rankings according to frequency within each province in red.

	Pregnancy and childbirth	Circulatory problems	Digestive system	Respiratory system	Injuries, poisoning	Malignant or benign tumors	Genito-urinary	Various symptoms and conditions	Mental disorders	Musculoskeletal, connective tissue	Secondary factors influencing health	Nervous system and sensory organ	Endocrine, nutritional, metabolic, immunity	Infectious and parasitic	Skin and subcutaneous tissue	Blood and blood-forming organs	Hereditary and congenital	Fetuses and newborn
Canada	174.2 1	151.1 2	124.4 3	105.7 4	90.3 5	74.1 6	68.7 7	60.6 8	59.6 9	49.4 10	45.6 11	30.4 12	21.9 13	17.3 14	13.5 15	8.4 16	7.2 17	6 18
NF	147 3	189.4 1	156.8 2	130.2 4	91.3 6	76.5 8	95.6 5	83.3 7	50.1 10	49.6 11	64.3 9	34 15	32.5 13	18 18	17.1 14	12.9 10	7.8 17	4.1 18
NS	155.8 2	178.1 1	144.3 3	124.2 4	88.8 5	80.8 6	71.6 7	71.3 8	59 9	57.1 10	53.2 11	32.6 12	25.9 13	16.2 16	13.4 15	7.9 17	10.0 10	4 18
PE	184.5 2	138.2 4	164.1 3	185.2 1	83 9	88.8 5	91.9 7	121.4 5	93.2 6	44.5 18	31 12	31.5 11	25 13	23.5 14	20.7 15	6.9 16	3.5 18	4.2 17
NB	154.3 4	196.4 2	192.7 3	200 1	104.1 7	62.3 8	106.8 6	111.7 5	78.6 8	63 11	65 10	44.5 12	29.3 14	30.3 13	22.4 15	11 16	4.4 17	4.1 18
QC	163.1 1	154.9 2	120.2 3	97.7 4	75.7 8	80 5	68.4 7	48.8 9	50.7 8	43.5 10	31.5 12	37.4 11	17.6 13	16.4 14	14.9 15	8.1 18	7.5 17	4.1 18
ON	174.4 1	147.4 2	113 3	92.1 4	86.1 5	74.7 6	65.7 7	56.8 8	53.8 9	48.1 10	47.4 11	24.7 12	22.2 13	16.1 14	12 18	6.9 18	7.4 17	6.7 16
MB	233.7 1	138.6 2	135.9 3	123 4	103.6 5	74.4 6	67.5 7	66.1 9	90.3 10	46.3 13	67.4 8	29.2 12	22 6 13	16.9 15	18.1 14	7.3 18	6.9 17	3.8 18
SK	206.7 1	170 4	160.8 3	189 2	125 5	77.8 8	95.2 6	89.6 7	77.6 9	72.5 10	56.4 13	44 15	32 12	23.7 16	17.2 19	11.6 16	7.8 17	6.3 18
AB	185.5 1	141.6 2	129.9 3	116.7 4	115.2 5	65.4 7	67.2 6	61.7 8	67.9 6	54.4 16	49.2 11	25.1 12	26.7 12	18.3 14	12.2 18	8.7 16	6.7 18	8.2 17
BC	171 1	136.8 2	117.5 3	91.2 5	116.9 4	62.3 6	58.8 7	65.7 8	60 6	51.3 10	46.3 11	29.5 12	18.8 12	18.5 14	10.8 15	6.1 17*	6.1 17*	7.4 16

*Tie. Statistically adjusted for age and sex factors in each province

Examples of diagnoses

PREGNANCY AND CHILDBIRTH early labor, normal delivery, problems with fetus
CIRCULATORY PROBLEMS aneurysm, heart attack, heart disease
DIGESTIVE SYSTEM appendicitis, gall bladder disease, ulcers
RESPIRATORY SYSTEM asthma, bronchitis, emphysema, pneumonia
INJURIES, POISONING burns, fractures, medical and surgical complications
MALIGNANT OR BENIGN TUMORS lung, breast, prostate and other cancers
GENITO-URINARY DISEASES bladder and kidney infections, kidney failure
VARIOUS SYMPTOMS AND CONDITIONS abdominal and chest pains, convulsions
MENTAL DISORDERS depression, schizophrenia, anxiety
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISEASES rheumatism, rheumatoid arthritis, slipped discs and other back problems
SECONDARY FACTORS INFLUENCING HEALTH convalescence, rehabilitation
NERVOUS SYSTEM AND SENSORY ORGAN DISEASES cataracts, epilepsy, glaucoma
ENDOCRINE, NUTRITIONAL, METABOLIC AND IMMUNITY DISORDERS diabetes, gout, goiter
INFECTIOUS AND PARASITIC DISEASES meningitis, tuberculosis, whooping cough
SKIN AND SUBCUTANEOUS TISSUE DISEASES infections and abscesses, dermatitis
DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS anemia, diseases that attack white blood cells
HEREDITARY AND CONGENITAL CONDITIONS cleft lip and palate, congenital hip displacement
PROBLEMS OF FETUSES AND NEWBORNS premature infants, abnormal fetal heart rate, slow fetal growth

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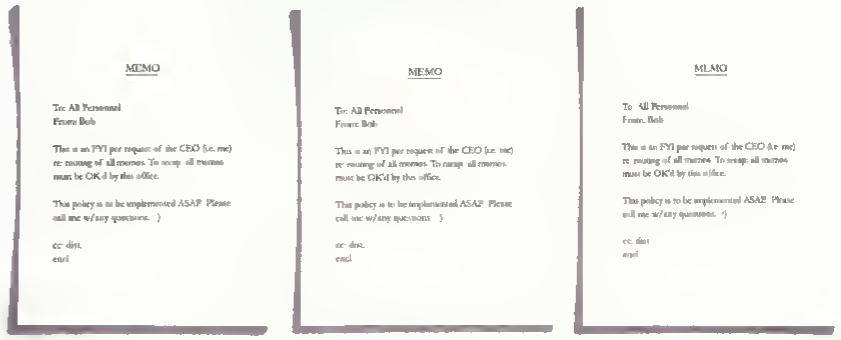

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HEWLETT PACKARD
Expanding Possibilities

What keeps hospitals busy

In the national statistics tracking medical and surgical procedures in hospitals, high cardiovascular surgery rates in the eastern part of the country stand out, with Newfoundland, New Brunswick, Nova Scotia and Quebec all reporting above-average levels of operations involving the heart. Canadians in other parts of the country appear less prone to cardiovascular problems. Ontario, Manitoba, Saskatchewan and British Columbia all have rates below the national average. Yet some experts contend that heart disease, in theory, can be beaten. If Canadians were more willing to get more exercise and forgo smoking and fatty diets, says Dr. David MacLean, an epidemiologist at Dalhousie University in Halifax, cardiovascular disease could become a rarity. "The problem," adds MacLean, "is that our society has yet to put a concerted effort into the lifestyle and environmental changes that are needed."

Still, in some provinces, things may not be precisely as they seem. Nova Scotia's high numbers for heart operations may be inflated by residents from other Atlantic provinces who go to Halifax for surgery, while Prince Edward Island's low rate reflects the fact that few cardiovascular procedures are performed on the island. Besides having one of the highest rates for heart surgery, New Brunswick shows elevated levels for procedures involving the digestive and lymphatic systems, as well as the eyes, nose and throat. Elsewhere in the country, Saskatchewan has the highest levels for gynecological operations, including hysterectomies, and procedures involving the musculoskeletal and nervous systems and skin.

Although this reporting system does not distinguish cancer surgery from other kinds of operations, the highest rates for respiratory surgery—which includes procedures involving lung cancer, the most lethal form of the disease for both sexes—were in Nova Scotia, New Brunswick and Manitoba. The lowest were in Ontario and Newfoundland. New Brunswick, Saskatchewan and Quebec had the highest rates for breast procedures—which include breast cancer operations—while Newfoundland and Nova Scotia had the lowest. For male genital operations, including prostate cancer surgery, New Brunswick, Prince Edward Island and Saskatchewan had the highest rates, while the lowest were in Quebec, Nova Scotia and Alberta.

MARK NICHOLS

Medical and surgical procedures

Patients in acute-, convalescent and chronic-care facilities receive medical and surgical procedures at differing rates across the country. The chart shows primary procedures per 10,000 population in 1995-1996 in numerical order nationally, and their provincial rates, with rankings according to frequency within each province in red

	Obstetrical	Diagnostic, therapeutic	Digestive, abdominal	Musculo-skeletal	Cardio-vascular	Gyneco-logical	Nose, mouth and throat	Urinary tract	Nervous system	Male genital	Respiratory system	Skin, subcu-taneous tissue	Breast	Eyes	Blood, lym-phatic systems	Ears	Endocrine system	Other, or no procedure
Canada	136.8 1	106.6 2	97.5 3	72.4 4	53.7 5	41.8 6	21.6 7	21.5 8	13.9 9	13.6 10	12.5 11	12.1 12	10.8 13	10.7 14	5.6 15	3.1 16	2.8 17	471.9
NF	103.8 3	135.1 1	112.1 2	62.9 4	59.6 5	52.2 6	35.6 7	29.6 8	11.5 13	13.9 9	12 11	13.3 10	7.3 14	9.2 13	6.5 16	4.5 16	3.4 17	584.2
NS	116.7 2	106 3	116 1	80.5 5	80.7 4	45.5 8	34.8 7	25 8	13.2 11*	12.7 13	15.9 8	13.2 11*	8.8 14	10.8 10	7 15	3.9 16	3 17	495.8
PE	113.9 2	115.5 1	111 3	50 5	20 8	55.7 4	36.6 6	28 7	8.5 13	17.2 8	12.5 10	9 12	11.2 11	6.7 14	3.2 16	4.3 16	1.4 17	720.6
NB	125.3 2	122.6 3	128.9 1	78.3 4	60.7 5	48.9 6	43.3 7	35.5 8	13.8 14	18.1 8	13.7 13	14.2 11	16.8 16	14 13	8.8 16	6.1 18	3.1 17	756.6
QC	129.9 1	102 2	100.1 3	59.4 4	56.1 5	50.7 8	14.5 16	17.2 7	15.6 8	11.2 14	12.4 11	13.2 12	11.5 13	10.1 8	8.8 16	3.9 18	2.6 17	438.7
ON	142.3 1	100.5 2	90 3	73.5 4	49.9 5	35.6 8	20.9 8	22.6 7	13.6 10	14.7 8	12 11	11 12	10.4 13	8.5 14	5.6 15	2.7 17	3.3 16	430.2
MB	129.6 1	103.7 2	96.4 3	67.1 4	49.5 5	48 8	20.6 7	19.8 8	8.8 12*	12.8 10	14.1 8	12.7 11	8.9 12*	8.8 14	8.8 16	1.9 17	3 18	603.6
SK	153.9 1	113.9 3	118.3 2	51.7 4	44.5 8	56.2 5	32.3 7	28 8	10.8 16	16.6 8	12.4 12*	14.5 11	13.4 12*	9.6 14	5.2 16	1.8 17	3.1 16	752.1
AB	149.5 1	128.9 2	89.7 3	85.3 4	54.9 5	45.1 6	23.2 7	15.9 8	12.4 13	12.4 10*	12.8 10*	12.8 8	10.2 13	8 14	4.7 16	2.8 17	3.4 18	470
BC	135.5 1	113.7 2	93.2 3	81.5 4	51.8 5	40.4 6	23.1 7	22.7 8	10.8 8	13.9 10	12.7 12	13.4 11	11.2 13	10.8 14	4.4 16	2.3 16	2.2 17	442.8

*Ties. Statistically adjusted for age and sex factors in each province

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Examples of procedures

OBSTETRICAL birth, amniocentesis, fetal monitoring
DIAGNOSTIC AND THERAPEUTIC nuclear medicine, ultrasound, CT, MRI and PET scan
DIGESTIVE AND ABDOMINAL appendectomy, gall bladder removal, hernia surgery
MUSCULOSKELETAL bone graft, fracture repair, hip and knee replacement
CARDIOVASCULAR coronary bypass, heart transplant, pacemaker implantation
GYNECOLOGICAL hysterectomy and other surgery
NOSE, MOUTH AND THROAT tonsillectomy, adenoidectomy and nose surgery
URINARY TRACT kidney transplant, bladder surgery
NERVOUS SYSTEM brain and spinal cord surgery, skull repair
MALE GENITAL circumcision, prostate surgery, vasectomy
RESPIRATORY SYSTEM lung biopsy and surgery, tracheotomy
SKIN AND SUBCUTANEOUS TISSUE biopsy, skin graft, repair of lip or mouth
BREAST biopsy, lumpectomy, mastectomy
EYES cornea transplant, cataract surgery, retina reattachment
BLOOD AND LYMPHATIC SYSTEMS bone marrow transplant, lymph node removal, spleen surgery
EARS biopsy, repair of eardrum
ENDOCRINE SYSTEM operation on adrenal, pituitary, thyroid and other gland
OTHER operations not completed, not otherwise specified, or no procedure performed

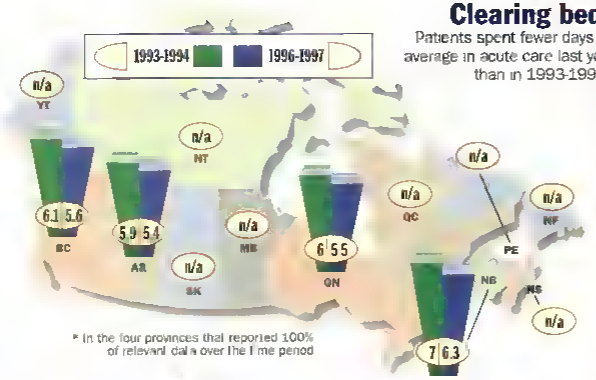
Getting discharged earlier

For several decades, the length of time people spend in hospital for any reason has been in free fall. As a result, Canadian hospitals now have fewer than one-third as many beds per person in the population than they did 30 years ago. Part of the change stems from the realization that keeping patients bedridden in hospitals can be a recipe for infections and problems brought on by immobilization. Technology is also hastening the process. For the past 50 years, the primary choice of treatment for an enlarged prostate has been a TURP (transurethral resection of the prostate), which uses a telescopic knife to remove tissue and allow freer passage of urine. Most provinces keep patients in hospital for between three and six days after a TURP, while Alberta regularly allows just two days for the procedure. But now, men can undergo less invasive methods of killing prostate tissue as outpatient procedures. Minimally invasive "key-hole" surgery has sped up recovery time for many other procedures by sparing patients the debilitating surgical wounds of the past.

Since the early 1990s, a drive to shut down beds and close entire hospitals has put a premium on rapid patient turnover to free up bed space. "But there is a limit," says Dr. Charles Wright, director of clinical epidemiology and evaluation at the Vancouver Hospital and Health Sciences Centre, "and we are approaching it. In many parts of the country, the number of acute-care beds is now under severe stress."

Clearing beds

Patients spent fewer days on average in acute care last year than in 1993-1994*



* In the four provinces that reported 100% of relevant data over the time period

Statistics have tracked the shortening lengths of stay in recent years in the four provinces that reported acute-care data. In British Columbia, Alberta, Ontario and New Brunswick, patients spent on average at least half a day less in acute care in 1996-1997 than in 1992-1993. Hospital stays for specific procedures—for which more complete national data is accessible—can vary dramatically among provinces, and between the regions. In the case of gallbladder removal—in which minimally invasive laparoscopic surgery is increasingly used—Prince Edward Island still keeps patients in hospital about four days, while Ontario typically whisks them through in a single day.

The pressure to reduce lengths of stay is not likely to let up. And for the most part, the experts applaud the trend as a way to get more out of the health-care system—as long as the support services for convalescing patients are in place. Alberta has increased spending on home and community care by 300 per cent since the early '90s, to $200 million this year. But in many provinces, the services are lacking. "The trend towards shorter lengths of stay can be a mixed blessing," says Dr. David Naylor, a clinical epidemiologist who heads the Toronto-based Institute for Clinical Evaluative Sciences. "If the home-care services aren't available, then you are dumping the load onto relatives and friends—it almost amounts to a user fee for families." That prospect lends added urgency to federal Health Minister Allan Rock's professed commitment to working with the provinces towards a national approach to home care. An infusion of federal money would help meet the immediate needs of patients whose time on a hospital bed is rapidly dwindling.

MARK NICHOLS

The short-stay trends

Median number of days spent in hospital for four procedures, 1995-1996

	Gallbladder removal (age 10+)	Total hysterectomy (age 20+)	Transurethral resection of the prostate (TURP) (age 50+)	Radical mastectomy females, age 25+)
NF	3	5	5	6
NS	2	4	4	5
PE	4	6	6	6
NB	2	5	5	5
QC	3	6	5	5
ON	1	4	4	3
MB	2	4	3	4
SK	2	5	5	4
AB	2	4	2	2
BC	2	4	3	3
Canada	2	5	4	4

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Accidents will happen

In the language of the World Health Organization, accidental harm to patients is known as "medical misadventure." By far the most common type in Canadian hospitals is an accidental cut, puncture, perforation or hemorrhage during medical care. The term also includes mismatched blood during transfusions, foreign objects left inside patients during operations, failure of sterile precautions and failure of an instrument or equipment. Canadian hospitals report reassuringly low rates for such events, according to data from the seven provinces that provide the information in a manner that allows for comparisons, misadventures befall fewer than one per cent of patients. In the United States and Australia, however, independent studies have shown rates ranging from four per cent to 20 per cent. Even in the absence of comparable studies, says Dr. Philip Hébert, a member of the University of Toronto's Joint Centre for Bioethics, "we can assume the rate in Canada is a lot higher than one per cent."

Most Canadian hospitals do not have effective reporting requirements for misadventures, adds Hébert. And doctors, fearful of lawsuits, often do not tell patients about mishaps. In fact, "most patients, when they are told, feel reassured," says Hébert. "What prompts many lawsuits is dishonesty and lack of disclosure."

	Patients having misadventure as percentage of hospitalizations, 1995-1996	Ranking (fewest to most)
NF	0.3%	3*
NS	0.8	6*
NB	0.2	1*
ON	0.3	3*
MB	0.2	1*
AB	0.8	6*
BC	0.5	5

*Ties

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

The warning signs

Is geography destiny? Residents of Newfoundland, and those in the Atlantic provinces in general, end up in hospital with heart attacks more often, on a per capita basis, than anyone else in Canada. British Columbians are least likely. Of course, it is not actually *where* people live that determines whether they suffer heart attacks, but often *how* they live. And when it comes to major risk factors associated with heart disease, particularly smoking and high blood pressure, easterners lead the country. According to "Heart Disease and Stroke in Canada," a 1997 report by the Heart and Stroke Foundation of Canada in conjunction with Statistics Canada and Health Canada, Newfoundland had the highest rate of smokers among 18- to 74-year-olds, at 36 per cent. Ontario and Saskatchewan had the lowest (23 per cent). Newfoundland and New Brunswick (27 and 26 per cent, respectively) also had the highest rates of patients diagnosed with high blood pressure. Alberta (17 per cent) had the lowest.

No matter where the patient lives, a heart attack can be devastating. Acute myocardial infarction—as it is known medically—occurs when an obstruction in one of the coronary arteries severely reduces or stops the blood supply to part of the heart muscle (the myocardium), causing irreversible injury. The blockage can result from a buildup of fatty substances called plaque or, less commonly, from a blood clot. Depending on how much heart muscle is damaged, the individual can be disabled—or die.

Still, the damage does not happen instantly. The longer an artery remains blocked, the greater the injury. That makes it vitally important to get treatment as soon as possible—instead of the two hours or longer that about half of all heart attack victims wait to go to hospital. The key is knowing the warning signs, which can include pain in the middle of the chest, and pain that spreads to the shoulders, neck or arms. But women may have other, less common, warning signs of a partial blockage, including abdominal pain, nausea and fatigue. The difference in symptoms may, in part, explain why 65 per cent of those hospitalized are men. Women simply may not recognize what is happening to them and therefore not seek treatment. Another possible contributing factor: women are, on average, a decade older than men when they have a heart attack—and may be more likely to die before ever getting to hospital.

Despite all the information available on heart disease, health experts say still more research is needed. The data, for instance, only show the rate of hospitalization, and do not account for people who die at home. "We don't have any measurements of heart disease incidence in this country," says Dr. Gregory Taylor, chief of the cardiovascular disease division of Ottawa's Laboratory Centre for Disease Control. As for variations among the provinces—including data showing that patients in Manitoba are most likely to die in hospital of their heart attack, while those in Alberta are least likely—Taylor says some of those stem from differences in how data are collected. That and other problems, he notes, will be addressed when the centre establishes a national cardiovascular surveillance system within the next few years.

BARBARA WICKENS

Where heart attacks strike

Hospitalizations for acute myocardial infarction (heart attack), 1995-1996

	Hospitalizations	Rate per 10,000 pop. (rank in red)		% males	% dying in hospital (rank in red)	
NF	1,273	23.1	1	62.8	13.4	5
NS	2,135	20.6	3	63.7	12.7	3*
PE	294	19.4	5	63.3	14	3
NB	1,873	22.8	2	63.2	13.7	4
QC	14,323	18.4	7	65.3	12.7	3*
ON	23,217	19.8	4	63	12.9	7
MB	2,091	16.1	9	63.2	14.5	1
SK	2,158	18	8	68.1	13.3	6
AB	4,685	18.8	6	71	10.1	10
BC	6,642	15.8	10	67.6	14.3	2
Canada†	58,764	18.8		65	12.9	

*Tie
† Includes data from territories

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

No room on the ward

They are called "bed blockers." Through no fault of their own, they took the blame late last winter when a flu outbreak and other factors combined to overwhelm emergency departments across the country. With the numbers of hospital beds drastically reduced in many areas, seriously ill new patients had to spend days on stretchers in the corridors. Meanwhile, comfortably occupying many of the acute-care beds in the wards upstairs were patients who should not have been there. Those bed-blockers were either well enough to leave but had nowhere to go for continuing care or were admitted unnecessarily for procedures or conditions commonly handled on an outpatient basis—such as a tonsillectomy or a bunion removal.

A problem for hospitals at any time, bed blockers have become more critical as acute-care beds disappear. One group is composed of patients who formerly had a genuine need for acute-care treatment, but have recovered enough to be moved somewhere else. For the most part, they have no one at home who is free and able to provide for their continuing needs, or those services are not available elsewhere in their communities. Hospitals designate those patients as ALC, for alternative level of care, and their numbers are growing. Of the six provinces that have reported comprehensive ALC data, only one—New Brunswick—managed to reduce their proportion over the past year.

Hospitals call another category of bed blockers MNRH, for may not require hospitalization. The "may" is important because some of those patients have complicating conditions that make hospitalization appropriate even for an MNRH procedure. That may include anyone with epilepsy or a heart condition, for instance, who is undergoing a tonsillectomy.

Several factors distort the rates in both bed-blocker categories, among them patients who travel great distances for treatment—as in the territories, for instance. They may be kept in a hospital longer than local residents because it makes no sense to send them all the way home while there is still any chance of complications. But with so little slack in the system, bed blockers anywhere are making hospitals an uncomfortable place for the sick and frail when they are admitted with no place free in the wards.

ROBERT MARSHALL

Stuck in bed

Percentage of patients discharged from acute care who were well enough to have been cared for elsewhere at least one day earlier (known as alternative level of care or ALC patients)

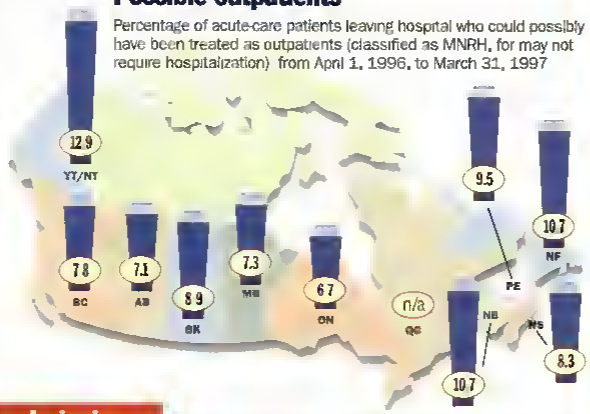
	1994-1995	1995-1996	1996-1997	% change '95-'96 to '96-'97
NF	n/a	0.45	0.64	+42.2
NS	n/a	0.57	0.77	+35.1
NB	0.17	0.22	0.19	-13.6
ON	1.84	1.91	2.05	+7.3
AB	0.84	0.76	0.87	+14.5
BC	n/a	1.04	1.37	+31.7

Data illustrate changes within each province over time. Only these provinces have reported data comprehensively over time, but comparisons between them may not be valid because they collect data differently.

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Possible outpatients

Percentage of acute-care patients leaving hospital who could possibly have been treated as outpatients (classified as MNRH, for may not require hospitalization) from April 1, 1996, to March 31, 1997



Dubious admissions

Canada's top 10 reasons that people may have been admitted unnecessarily as inpatients of an acute-care hospital, 1996-1997

	Diagnosis/procedure	Number of people leaving hospital
1.	Tonsil/adenoidectomy	17,987
2.	Urinary obstruction without complications	12,392
3.	Adjustment disorders (e.g., grief, culture shock)	12,050
4.	False labor, less than three days	11,090
5.	Simple transurethral or biopsy procedure without complications (e.g., exploration of prostate, removal of blood clot or kidney stone without incision)	9,452
6.	Simple procedure on legs or feet (e.g., removal of bunion, suture of ankle or ligament)	7,075
7.	Sprain, strain or other minor injury among patients under 65	6,397
8.	Obsolete psychiatric diagnosis (e.g. emotional disturbance with no pre-existing mental condition)	5,830
9.	Sore throat	5,795
10.	Nasal procedure (e.g., simple plastic surgery)	5,416

Data for chart and map unavailable for all Quebec cases. 60% in Manitoba, 17% in Prince Edward Island and roughly 1% in Saskatchewan.

SOURCE: CANADIAN INSTITUTE FOR HEALTH INFORMATION

Healthy habits, longer life

Being passed through the giant metal doughnut of a computerized tomography scanner, patients in a modern hospital might easily conclude that the wonderful advances in medical science surrounding them are responsible for Canadians living longer than ever. And while there is no disputing the lifesaving capabilities of modern medical care, a host of factors having little to do with high-tech equipment also contribute mightily to making Canada a healthier society. It is a fact that Norman Bethune, the Canadian doctor-hero of the Chinese revolution, noticed back in the 1930s. His contention that the conditions under which people live their lives—in Canada and elsewhere—are more important to longevity than medical treatment has become less controversial and more established with the passing years.

Health professionals now refer to those factors as the "determinants of health." They include the lifestyle choices people make for themselves, such as diet and smoking, as well as the choices that are made for them, such as the health of an infant's mother during pregnancy and the wealth of the communities where people live. "Poverty, poor food, unsanitary surroundings, contact with infectious [lesions], overwork and mental strain are beyond our control," a frustrated Bethune wrote in the 1930s. Decades later, a discussion paper adopted by the country's health ministers in 1994 noted in a similar vein that "factors such as living and working conditions are crucially important for a healthy population."

As Canadians debate how much money their governments should earmark for health care, some observers note that spending on hospitals and doctors may be one of the least effective ways of improving the health of Canadians. "There is mounting evidence," the health ministers' document said, "that the contribution of medicine and health care is quite limited and that spending more on health care will not result in further improvements in population health."

And while eating greens, keeping fit and not smoking are widely accepted as ways to improve health, the most important factors seem to be income and social status. The more control people have over their lives, the healthier they tend to be. "As your poverty goes up, unemployment goes up and education level goes down, you find increasing mortality," says Dr. John Millar, B.C. provincial health officer. "It's sort of a straight line relationship." Overall, citizens of wealthy countries live longer than those of poor countries. Similarly, within Canada, residents of wealthy provinces generally live healthier and longer lives than their fellow citizens in poorer provinces.

Ranking poorly on health risks and social and economic measures, Newfoundland also fares badly in measurements of people's health. That province has the shortest life-span for women, the second-shortest life span for men, the highest mortality rate from heart disease and the second-highest infant mortality rate in the country. On the other hand, British Columbians tend to live long and prosper. Its women live the longest, its heart disease mortality rate is the lowest, and its proportion of smokers is the smallest.

Millar says he is not surprised by British Columbia's good showing. But differences between provinces are relatively small, he cautions, and mask more significant differences within provinces. In British Columbia, people in urban areas have a life expectancy five years greater than people in northern and rural areas. Within Vancouver itself, there is a similar gap between the wealthy of Point Grey and the impoverished of the Downtown Eastside. Statistics on B.C. natives show an even wider difference, of 12 years less than the best life expectancies. "I don't think there's any room for gloating," says Millar. With all the measurements pointing to education's pivotal role in determining health, finishing the homework may be an even better strategy than finishing the broccoli.

WARREN CARAGATA

How healthy are Canadians?

Selected key measures of health with rankings in red.
A high ranking (low number) indicates a poorer health status. The composite ranking follows the same principle. The territories are not ranked because some data are not available.

	Life expectancy: men	Life expectancy: women	Infant mortality per 1,000 live births	Cancer deaths per 100,000 pop.	Heart disease deaths per 100,000 pop.	Suicide rate per 100,000 pop.	Composite total	Composite ranking
NF	74.8 2*	80.5 1	7.8 2	189.3 5	216.6 1	6.5 10	21	1
NS	74.9 2*	80.8 3*	4.8 8	209.8 1	188.4 4	12 5	23	2
PE	73.9 1	80.8 3*	4.6 10	206.7 2	212.6 2	6.6 9	27	3
NB	75.2 5	81.2 5	4.8 8	192.6 4	188.9 3	12.1 4	30	5
QC	75.1 4	81.5 8*	5.5 7	202.6 3	175.1 8	18.4 1	31	6
ON	76.1 9*	81.4 7	6 5*	179.8 7	175.7 7	8.4 8	43	8
MB	75.4 7	80.7 2	7.6 3	184.6 6	188.2 5	10.6 6	29	4
SK	75.3 6	81.5 8*	8.1 1	171.6 8	173.7 8	14.3 3	36	8
AB	76 8	81.3 6	7 4	173.8 8	177.3 6	16.2 2	34	7
BC	76.1 9*	81.8 10	6 5*	166.3 10	155.6 10	8.6 7	51	10
YT	70.9	84.4	12.8	209.8	232.3	34.5	n/a	n/a
NT	69.8	75.8	13	284.6	170.5	31.6	n/a	n/a
Canada	75.7	81.4	6.1	184.5	175.2	12.9		

* Ties
Figures for infant mortality are from 1995. All others are from 1996. Life expectancy is measured at birth.

SOURCE: STATISTICS CANADA

Not just medicine

Social factors' status at birth and lifestyle choices—with rankings in red—play a big role in determining health.
A high ranking (low number) indicates a poorer health status. The composite ranking includes weight data shown in the map (right). The territories are not ranked because some data are not available.

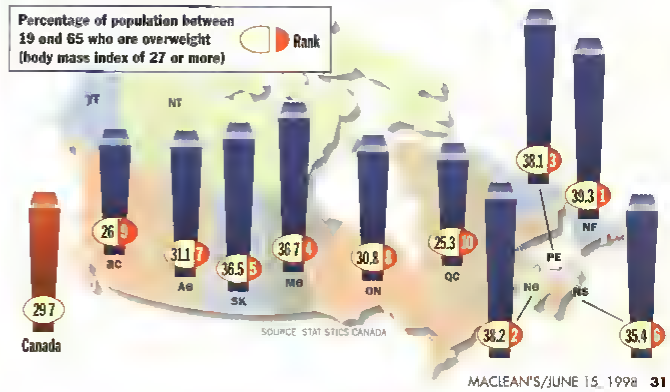
	Incidence of low income**	Government transfers as percentage of total income	Unemployment rate, May***	Less than Grade 9 education****	Low birth-weight babies†	Smokers††	Percentage of women having Pap smears†††	Composite total of all rankings	Composite rank
NF	21.4 2	24.6 1	16.8 1	17.5 2	5.48 7	25.69 5	85.87 4	23	1
NS	18.8 6	18.1 4	10.4 5	11.1 7	5.96 3	27.26 2	89.12 6	39	4*
PE	15.2 10	22.1 2	13.5 2	13.3 4	4.62 10	27.24 3	88.46 6	39	4*
NB	18 5	18.7 3	12.7 3	16.5 3	4.78 8	26.21 4	85.31 3	32	3
QC	23.4 1	16.2 5	10.5 4	18.1 1	5.95 4	29.06 1	76.08 1	27	2
ON	17.7 8	12.5 9	7.1 7	10 8	6.06 1	22.44 9	85.23 2	53	7
MB	20.6 3	15.1 7	5.3 10	12.6 6	5.5 6	23.95 7	90.79 8	52	8
SK	16.3 8	15.8 6	5.4 9	13.2 5	5.58 5	23.98 6	92.6 10	54	8
AB	18.4 7	10.8 10	5.7 8	7.5 8	5.99 2	23.12 8	89.52 8	59	8
BC	18.6 4	12.7 8	9.7 6	7.4 10	5.29 8	18.88 10	89.31 7	62	10
YT	n/a	9.2	n/a	5.7	4.26 n/a	n/a	n/a	n/a	n/a
NT	n/a	8.4	n/a	20.4	6.94 n/a	n/a	n/a	n/a	n/a
Canada	19.7	14	8.4	12.1	5.84	24.29	84.49		

*Ties **Based on percentage of household income spent on necessities ***Seasonally adjusted, for population over 14 years ****Percentage of population over 14 years
† Newborns less than 2,500 g as a percentage of live births †† Percentage of population over 11 years smoking cigarettes daily
††† Percentage of women over 17 who reported ever having a Pap smear

SOURCES: 1996 CENSUS; NATIONAL POPULATION HEALTH SURVEY: 1994-1998; HEALTH STATISTICS DIVISION, STATISTICS CANADA

Weight and wellness

Obesity is a major health problem in Canada and the developed world in general, leading to a wide range of demands on the health-care system. One method of roughly determining a healthy weight is the body mass index, calculated by multiplying your weight in pounds by 703 and dividing that result by the square of your height in inches (height multiplied by itself). An index reading between 20 and 24 is considered acceptable for most people. Anyone with a reading less than 20 may be susceptible to health problems associated with being underweight. Health problems associated with being overweight begin to appear at an index rating of 25. Readings of 27 or more indicate an increased likelihood of developing health problems associated with obesity.



Consistently above average

Canadians, as a people not given to effusive displays of national pride, have always taken pleasure in the country's role as a middle power. Not the wealthiest or strongest, but neither poor nor inconsequential—just nicely above average. Yet when it comes to measuring the health of people around the world, the human development index, produced by the United Nations Development Program, annually ranks Canada on top. That is because the above-average Canadians consistently place near enough to the top—on enough counts—that overall the country emerges in first place.

But nothing measures health quite so directly as life expectancy. On that score, the reigning champions among the Group of Seven leading industrial countries are the Japanese—men and women. Right behind Japanese men come Canadian men, at 75.8 years. Among women, Canadians rank third at 81.3 years, trailing the French. The fact is, the key measurements of a society's health emerge not so much from the superiority of its medical care as from the levels of its wealth and education. As people in Ontario are generally healthier than their fellow citizens in Newfoundland, so, too, are Canadians generally more healthy than Mexicans. While differences between developed countries are relatively small—about half a year separates life expectancies for women in France and Canada—Canadian women live, on average, more than five years longer than Mexican women. The infant mortality rate in Mexico is more than 2½ times the Canadian rate.

Canada used to rank near the top of the G-7 pack on how much the country spent on health care as a share of gross domestic product—tied with Germany for second place behind the United States in 1992. But fiscal restraint has taken its toll. By 1995, Canada had slipped to fourth—behind France and Germany—as a result of a cutback trend that has continued since then. But while the Americans are still by far the leaders, that has not translated into good health for all—their life expectancy is the lowest and their infant mortality rate the highest in the G-7. Japan, which spends half what the United States does as a percentage of GDP, ranks best on both counts.

In 1994, the latest year for which full comparative figures are available, Canada was still spending more on in-patient care—generally hospitals—as a portion of overall health spending than any other G-7 country except Italy, and almost 50 per cent more than the Japanese. But hospitals have borne the brunt of spending cutbacks since then. The next time such international comparisons are done, Canada most likely will emerge somewhat lower in the pack—even if it remains above average.

WARREN CARAGATA

Bragging rights

Whatever the shortcomings of Canada's health-care system, the country must be doing something right. For the past four years, Canada has ranked first in the United Nations Development Program's annual human development index—broadly interpreted as meaning the best country in which to live. The HDI combines data on life expectancy, standard of living, educational levels and literacy for 175 countries. The next ranking is expected in September. The top 10 in 1997:

1. Canada
2. France
3. Norway
4. United States
5. Iceland
6. Netherlands
7. Japan
8. Finland
9. New Zealand
10. Sweden

SOURCE: UNITED NATIONS DEVELOPMENT PROGRAM

A global accounting

Key measures of the state of health and levels of health-care spending in the leading industrial countries, plus Mexico (ranking in red)

	Life expectancy, women		Life expectancy, men		Infant mortality*		Heart disease mortality, women†		Heart disease mortality, men†		Lung cancer mortality, women†		Lung cancer mortality, men†		Health expenditures as % of GDP		Spending on in-patient care as % of total health spending		Spending on physicians as % of total health spending	
	1995		1995		'94/'95		1992		1992		1992		1992		1995		1994		1994	
Canada	81.3	3	75.3	2	0.63	5	200.2	5	798.8	5	247.6	7	421	5	9.8	4	46.3	2	14.8	5
France	81.9	2	73.9	5	0.58	3	65.4	2	387.7	2	64.6	2	516.9	8	9.8	3	44.8	3	11.9	6
Germany	79.5	8	73	8	0.53	2	190.1	4	837.1	6	95.4	5	418.4	4	10.4	2	38.4	8	16.7	4
Italy	81	4	74.4	3	0.66	8	112.1	3	579.6	4	80.8	4	488.5	7	7.7	5	47	1	20.6	2
Japan	82.8	1	78.4	1	0.43	1	44.5	1	162.4	1	70	3	188.2	2	7.2	8	31.1	7	35.2	1
Mexico	78	8	69.5	8	1.7	8	234.6	6	553.9	3	54	1	118.2	1	4.9	8	n/a	n/a	n/a	n/a
United Kingdom	79.7	5	74.3	4	0.82	4	323.4	8	1,244.5	8	178.4	8	364.5	3	6.9	7	42.6	5	n/a	n/a
United States	79.2	7	72.5	7	0.8	7	305.5	7	951.9	7	259.2	8	476.4	8	14.2	1	43.5	4	20.3	3

*As a percentage of live births. Figures for Germany and Japan are from 1995, the others are from 1994.
†Shown as potential years of life lost, calculated by taking the median age in each age-group, subtracting from 70, and multiplying by the number of deaths in that age-group, broken down by sex and cause of death. The result of the calculation shows the number of potential years of life lost from a particular cause per 100 000 population.

SOURCES: STATISTICS CANADA, WORLD HEALTH ORGANIZATION, ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

A

is for Amazing, b, c and d for Digital Video, e and f for Families, g, h and i for Images, j, k, l and m for Man businsss usss. n o, p, q, r, s and t for Travel, u, v and w for Weddings, x and y lssds yos to

ZR

The point and shoot camcorder.

The ZR is Canon's new digital video camcorder – but you wouldn't know it from looking at it. Canon designed the ZR to be easy to use by adopting the familiar look and comfortable feel of "point and shoot" cameras. But don't be fooled. This incredibly compact, lightweight (a mere 1 lb , 3 oz.) masterpiece of technology shoots high quality digital video images and doubles as a digital camera that you can connect to a TV or a VCR. The ZR features a flip-up viewfinder that makes shooting digital video a pleasure. The images you record on the ZR are easily downloaded into a PC for storage, manipulation, or for web site development and e-mail correspondence (with the optional DK-1 capture kit). Which brings us back to i for imagine – imagine how you can use it.

Canon's ZR digital video camcorder – now you know your A to ZR's.

Canon

For more information about Canon's complete line of digital products, visit www.canondv.com or call 1-800-OK CANON

The Canon ZR Digital Camcorder with flip-up LCD Screen for viewing your images instantly

Imagine the possibilities.

Shocks to the system

BY JOHN DeMONT

TODD KOROL FOR MACLEAN'S

Calgary's Bow Valley Centre: an institution awaiting demolition

The scalpel of health reform has left painful wounds

What happened in Brantford, Ont., late last month differs only in detail from the wrenching experiences of communities across Canada. On May 20, Romeo Cercone, CEO of St. Joseph's Hospital, received the news he was dreading: confirmation that his 101-bed chronic-care rehabilitation facility will close in April, 2000. "I was numb," says Cercone. Only a fraction of its 400 employees will have work at the one remaining hospital serving an area population of 125,000, the 220-bed Brantford General. The southwestern Ontario community has tried for six months to muster arguments for keeping St. Joseph's open, but members of the Ontario Health Services Restructuring Commission were unmoved. "They had made up their minds that there was going to be one facility in Brantford," says Cercone. "It was ideology, plain and simple."

Unpopular hospital closures. Huge backups in emergency. Patients kept for days on stretchers in corridors. Long waiting lists for surgery. Disgruntled doctors. Angry nurses. Is the health-care system out of control? For at least a decade, health-care experts have been preaching the need to revamp the system, to get more care and preventive measures out into the community where they are needed. In practice, however, the pace of the wholesale restructuring that has cut through provincial health-care systems like so many scalpels has been driven not by prudent medical planning but by fiscal priorities—the preoccupation with balanced budgets. And somewhere along the line, many of the provinces got things backwards. They pared back acute-care facilities before they had the necessary rehabilitation and home-care programs in place in communities. "It is a little like the banks shutting down their branches before they've built enough automated teller machines," observes Toronto-based health-care consultant Michael Decter, chairman of the Canadian Institute for Health Information.

Money, naturally, is at the root of the problem. As the federal fiscal crisis deepened, Ottawa slowed the flow of health-care funds to the provinces. (The Canada Health and Social Transfer—the main block of federal funding to the provinces—fell to $12.5 billion in 1998-1999, from $19.3 billion in 1994-1995). Coincidentally, the federal cutbacks came at a time when the provinces were already in the midst of the biggest rethinking of health care since the Pearson government introduced medicare in 1966. The solution, on the face of it, seemed obvious: save funds by shutting down acute-care beds, then use the money to reshape the system to meet the needs of the baby boomers who will be hitting old age within 15 years. A mass of heart bypass patients, for instance, will require help at home after being expelled from hospital within a few days of lying on the operating table.

While the strategy seemed to make sense, the problem has been in the execution. Canadians understandably grow uneasy when they hear of patients dying before being seen by medical staff in crammed emergency wards, as may have been the case in two instances, in Quebec and Manitoba, in the past winter; or when their rural hospitals are downgraded to community-care centres or closed altogether. They are concerned by what they hear about burned-out nurses and about overextended working parents struggling to look after their own aged and ailing parents at home because there are no alternatives in the community.

Whether the chaos represents short-term bottlenecks in the system or deep-seated problems that will only worsen with time is unclear. Decter, for one, says that although some critics—primarily physicians' organizations—have been "crying wolf for years," it is a relatively manageable situation. "Some problems will take time to solve," he adds, "but the prognosis is helped by the fact that people are taking better care of themselves."

However long it lasts, the disruptions are already making it difficult

for people to plan for the future, knowing that the health-care system may become largely unrecognizable. In 20 years, when the oldest of Canada's 9.8 million baby boomers have reached their 70s, many will require extensive health care. As well, improved drugs, new technologies and less invasive surgical techniques are dramatically reducing—in some cases eliminating—hospital stays for procedures that once required long periods in bed, exposed to disease and infection that could be just as troublesome as the original illness.

The day looms when babies are (again) regularly delivered at home and cardiac patients lying in their own beds are monitored electronically by doctors and nurses miles away. The upshot, almost certainly, will be a new type of health-care system—one in which hospitals mainly dispense services, and most of the post-treatment recovery, the rehabilitation and chronic care takes place in the home or a less-costly rehabilitation institution. "The goal," says Duncan Sinclair, head of Ontario's Health Services Restructuring Commission, which is reshaping the province's health-care delivery, "is to build an integrated health system, a partnership between a whole range of providers offering a whole range of services."

A tectonic shift of that sort involves a massive reinvestment. Preparations are now under way for demolition experts to collapse the empty Bow Valley Centre, a once-proud 400-bed Calgary hospital that shut its doors in April, 1997. As much as anything, that facility's demise symbolizes the shift taking place from big institutions to community-level health care. So far, the pain has been least in provinces like Saskatchewan and British Columbia, which were already far advanced in their reforms when the fiscal crunch hit. Other provinces have found it more difficult to cope with major funding cuts as they struggle to restructure their own health-care system.

Home care is the next priority

Transfering Bow Valley patients last year: is the system out of control?

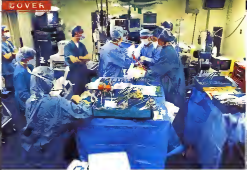
Consider Nova Scotia, which in the early 1990s enjoyed one of the highest hospital-bed-to population ratios in the land, but had dropped to ninth place by 1995-1996. Since Russell MacLellan became premier last year, the Liberal government has shored up the system with an additional $100 million for doctors' pay and a system of tele-medicine—using electronics to keep rural patients in touch with urban specialists. But it was clearly not enough to deflect Nova Scotians from other pressing concerns: the decline in hospital beds—about 3,500 today versus 5,947 in 1986-1987—and the downgrading of three rural hospitals to community health centres. Health care was a big issue when the province went to the polls in April, and MacLellan's Liberals barely survived with a vulnerable minority government.

That is not likely to instil confidence in other provincial governments facing elections as they try to reshape health care. In Ontario, for example, where an election is expected next year, the winter flu outbreak overwhelmed many emergency departments. And that was even before the 40 hospitals that a commission has fingered for closure have shut their doors. Not surprisingly, Premier Mike Harris's Conservative government, which has been working earnestly to repair its hardhearted image, has pledged to open 20,000 more long term-care beds and another 100,000 home-care places.

That is certainly a start. For now, Canadian governments spend roughly $2 billion annually on home care—less than three per cent of the country's $76.6-billion overall health-care spending. Experts generally agree that is far too little to cope with the emerging needs. The home- and community-care demands seem staggering. They span the simplest questions—who will bring bedridden seniors their meals?—to the most complex, such as the kind of psychological support the person carrying the burden of the patient's care will need.

And, inevitably, who will pay for it? Provinces have no obligation under medicare's Canada Health Act to provide home care. But every province has voluntarily established a system in which patients at home are either looked after by government employees or the work is contracted out to nonprofit or commercial home-care agencies. Overall, though, Canada is a home-care crazy quilt with a wide discrepancy between the levels of services available from one province to another.

That is where Ottawa could come in. Experts like Decter say home-care services should be covered under medicare. One complication could be the stiff resistance from the provinces to allowing Ottawa to set standards and principles for home care, then leaving the provinces to pay for the expensive system. And while federal Health Minister Allan Rock says he is determined to put home care at the heart of the Canadian health-care system, his strategy has been sidetracked by the furore over hepatitis C compensation. That may be bad news for the Liberals who want to get public credit for spending money directly on home care. Before Canadians can become confident that the health-care crisis is under control, there will be many more Brantfords to make them wonder. □



David's open-heart surgery team at work: the risk of dying during the operation has dropped dramatically

Healing hearts

Cardiologists' patient lists are growing

BY D'ARCY JENISH

Tirone David, one of Canada's busiest heart surgeons, walks briskly into the operating room at The Toronto Hospital at 9 a.m. sharp. The eight-member team of doctors and nurses who will assist the 53-year-old, Brazilian-born surgeon has completed all the preliminaries. The patient, a man in his late 50s, has been anesthetized. He has been connected to monitoring and life-support machines. And his chest has been opened to expose his heart. Under David's scrutiny, the patient receives a potent muscle relaxant that stops his heart, and a bypass machine begins pumping oxygenated blood through his body.

Then the tall, slender surgeon goes to work. He snips out a defective valve and stitches in an artificial replacement. He cuts out tiny, tear-drop shaped fragments of exterior tissue and sews up the incisions to reduce the size of the man's stretched and damaged heart and make it pump more effectively. Finally, he removes an aneurysm—a dilated blood vessel that could burst and lead to death. In less than two hours, David is finished and the patient's heart is beating again. "I think he's going to be OK," the surgeon says as he leaves to prepare for his next patient, a 41-year-old man with severely blocked arteries.

David now performs two or sometimes three operations daily, and up to 450 annually—30-per-cent more than five years ago. And his situation is not unusual. Most of Canada's 187 cardiac surgeons have seen their workloads increase dramatically as the country's population grows and ages simultaneously, resulting in a sharp increase in the incidence of heart disease. At the same time, surgeons and cardiologists, like other health-care professionals, have become much more efficient because of budgetary constraints. They are discharging patients—even organ transplant recipients—earlier and prescribing fewer postoperative tests, changes that have freed up hospital beds and, in some cases, shortened waiting lists. "Efficiencies are occurring in almost every industry," says Dr. Arvind Koshal, chief of cardiac surgery at the University of Alberta Hospital in Edmonton. "IBM has to do it, Xerox has to do it, and so do we."

Cardiovascular disease, which includes strokes and other circulatory ailments, claims the lives of an estimated 79,000 Canadians annually—matched only by all cancers combined as a leading cause of death. Surgeons are continually looking for new procedures or devices that will improve results. Over the past two years, Dr. Raymond Cartier of the Montreal Heart Institute has performed more than 200 bypass operations—in which a vein from the leg or the chest is grafted to the heart to replace a clogged artery—without stopping the patient's heart. Cartier uses a metal device of his own design to immobilize a small section around the damaged artery. By allowing the rest of the heart to function during surgery, says Cartier, patients require less transfused blood, run a lower risk of suffering a stroke and can be discharged from hospital earlier. "For a heart surgeon, doing a triple bypass with the heart beating is like an astronaut walking on the moon," he says. "It's something you'd like to do, but never imagined it would happen."

Meanwhile, a colleague, cardiologist Raoul Bonan, has obtained promising results using mildly radioactive material to treat clogged arteries. He employs the technique during angioplasty, a procedure that involves running a catheter—a narrow tube—through an artery from the thigh to the heart. Then, the cardiologist either inflates a miniature balloon to break up a blockage, or inserts a spring-loaded device to open the artery. However, in nearly 40 per cent of patients, the artery becomes blocked again within six months. Now, Bonan deposits tiny ceramic pellets containing radioactive material to prevent the growth of new cells and a recurrence of the blockage. At an international conference in Washington in March, Bonan reported that only three of 30 patients who received the treatment had experienced new clogging after six months.

Perhaps the biggest change in recent years has been the 37

SONY

For once, we'd like you to think inside the box.

At the risk of offending corporate consultants throughout the world, we'd like to remind you what moms everywhere already know. It's what's on the inside that counts. That having been said, GS series allow us to introduce the new GS Series from Sony. A pair of Trinitron® displays uniquely designed to meet the rigours of even the most demanding office environments. As you can see, the GS Series is packed with more new ideas than most brainstorming sessions, not to mention the quality, reliability and compatibility you've come to expect from Sony. **To receive the inside information on these new displays, go to www.sony.ca or call 1-800-961-7669.**

displays by sony

An advertising supplement to the June 15, 1998, issue of Maclean's magazine

Becoming DIGITAL

in the 21st Century

More and more we live in a digital world.

The CDs we listen to store music as digital bits and bytes. When we use a debit card to pay for the week's groceries, funds are transferred digitally from our bank accounts to the store's. When we send an e-mail message to someone on the other side of the planet, digital bits carry our missive along sophisticated computer networks.

As we enter the 21st century, the trend to digitalization is accelerating. Canadians can carry out banking transactions over the Internet, paying bills and transferring funds digitally. They can load electronic cash into smart cards, and use it to feed the parking meter or pay bus fares. They can use the Internet to go shopping in online stores with huge selections and great prices. They can take digital snapshots, and with the click of a button send them to loved ones a continent away. They can phone anywhere in the world over new wireless digital communications networks.

Making Pictures by Numbers

Digital photography has to be one of the most fun things you can do on your computer. With the right software, you can remove flaws like "red eye" from your snapshots, brighten up a dull photograph, alter the color balance, and even combine two pictures into one. Then when everything is just right, you can make a print that looks like it came from the photo lab. You can also include your picture in a greeting card, or e-mail it to friends and family thousands of miles away.

Smile for the digital camera. Digital cameras, like this Hewlett-Packard PhotoSmart C20 model, allow pictures to be stored electronically and transferred to a computer for modern photo finishing.

To get pictures into your computer, you can use a digital camera. Instead of registering images chemically on photographic film, digital cameras store pictures electronically on memory cards. You transfer images from the camera to the computer using a special cable and software that come with the camera.

Basic digital cameras start at around $300. You will get much better picture quality from one of the new "mega-pixel" models. Available from companies such as Agfa, Canon, Epson, Hewlett-Packard, Kodak and Olympus, mega-pixel digital cameras start at around $900. At print sizes as large as five by seven inches, picture quality is as good as with conventional cameras.

You can transfer printed pictures to your computer using a scanner. Capable models are available for as low as $200. If you are willing to spend more to get superb image quality, check out Hewlett-Packard's $700 PhotoSmart scanner. In addition to scanning pictures, it scans 35mm slides and negatives, and produces professional quality results.

If you want to experiment with digital photography, you can have a photo store convert your images to electronic form. Photo retailer Black's will scan images to CD or diskette. For $5.49, the company will scan an entire roll of film to its Internet site. You can then download your pictures to your computer and/or e-mail them to someone else.

Once you have transferred pictures to your computer, there are all kinds of things you can do with them. With simple image editing software like Photo Deluxe from Adobe Systems, PhotoSuite from MGI Software, and Picture It! from Microsoft, you can spruce up your images: cropping

Digital Imagery Digital cameras, printers and photo scanners, like the Hewlett Packard PhotoSmart system allow users to make prints that look like they came from the photo lab

the picture to leave out distracting material, lightening a subject that is too dark or sharpening a picture that is a little blurred. These packages will also help you make greeting cards and other documents.

Canon, Epson, Hewlett Packard and Lexmark all have excellent general-purpose color printers that will do a good job printing the photographs from your computer. But if you are really serious about computer photography, consider a printer designed primarily for photo printing. Epson's new Stylus Photo 700 and HP's PhotoSmart printer can produce pictures that look as vibrant and detailed as conventional photographs.

Digital Banks Are Always Open

Canadians are some of the most inveterate users of electronic banking services on the planet. Now they are eagerly adopting PC (personal computer) and Internet banking. Canada Trust has 215,000 customers using its EasyWeb service. At Toronto Dominion Bank, 180,000 people use TD Access PC and TD Access Internet. Over 240,000 people use CIBC PC banking.

With PC or Internet banking, you can view balances and activities on deposit accounts, view balances and activity for credit card and some loan accounts, transfer funds between accounts, and pay utility and other bills. You can even postdate payments, in case you are going to be away when a particular bill comes due. If you buy mutual funds or securities through your bank's retail brokerage, you can probably view your portfolio, get quotes and initiate trades.

The newest division of Bank of Montreal, mbanx, is built entirely around electronic banking. While mbanx customers can carry out transactions and get assistance at Bank of Montreal branches,

Facts at Your Fingertips

The Internet has masses of information on every conceivable subject. Sometimes, however, it is hard to know where to start.

If you are looking for information on a specific subject, your first stop should be one of the search engines. A search engine maintains information on the content of sites on the World Wide Web. You enter the address of the search site in your Web browser software. At the site, you enter "key words" describing the subject you want to explore. The search engine then lists sites that might contain the information you need.

There are dozens of search engines on the Internet. www.excite.com, www.lycos.com, www.yahoo.com, to name just a few. The most popular is Yahoo. Besides enabling users to perform keyword searches, Yahoo categorizes sites by subject matter. You can start by selecting a broad subject category, then narrow your search by selecting successive sub categories until you find something that interests you. Key word searching is faster if you know what you are looking for. Subject searching is better if you are not sure exactly what you want, or if you just want to do some casual browsing. The Canadian version of Yahoo, at www.yahoo.ca, lists Canadian sites first.

YAHOO! CANADA

Yahoo is moving beyond its origins as a search engine to become a general news and information site. Those features are being added to yahoo.ca. Plans for the site include a Canadian news section, sports, weather and a finance area.

The other way to make your Web foraging more productive is to list useful sites in the Bookmarks or Favorites section of your Web browsing software. After that, you can find your way there with a click of the mouse.

If there is a particular site that you always visit early on each time you are on-line, you can specify it as your start page. After that, you will be taken to the site you specify as soon as you log on, rather than starting at your Internet service provider's home page.

You can even get programs that automatically download information in categories that interest you from specific Internet sites. The software then displays the information on-screen for you to read off-line. Yahoo has a service that displays downloaded news information as a scrolling ticker tape.

Making Movies the Digital Way

There are few surer ways to alienate friends than to force them to watch your home videos. But if you can spruce up your videos by removing uninteresting stuff and adding some explanatory dialogue, you may be able to get your guests to stifle those yawns.

It is possible to edit your videos on your computer with special add-on editing kits. A board that fits inside your computer grabs video from your camcorder and loads it onto the hard disk. The software lets you delete scenes you do not want and change the order of the scenes you want to keep. You can even add special effects, background music and a voice-over track.

A computer package cannot turn you into James Cameron, but it can give you a little help. The Avid Cinema video editing software included with the new Marvel G200TV from Montreal-based Matrox Graphics has 20 storyboard templates to guide you through the creative process. Created by professional scriptwriters, the templates provide suggestions for camera angles, scene lengths and transition effects.

Once you have finished your masterpiece, you can copy it from your computer onto VHS videotape or publish it on the World Wide Web.

Hollywood at home: Specialized software packages, including the Matrox Marvel G200 with AV box, allow home video enthusiasts to professionally edit their masterpieces

mbanx is a direct bank. It has no branches of its own. Instead, customers perform transactions over the Internet, or by fax, phone, courier and mail or bank machines.

In some cases, banks offer discounts for banking online. At Canada Trust, flat fee accounts that emphasize self-serve transactions—including EasyWeb—are significantly cheaper than other accounts. Scotia Discount Brokerage reduces its trading fee by 20 per cent when you make the trade online.

Most banks do not charge for Internet banking, but just take the standard fees for bill payment. While Royal Bank has a monthly access fee, it provides a software program called Managing Your Money as part of the package. This lets you budget and track various household expenses.

It works much the same as popular personal financial management software such as Quicken and Microsoft Money. PC and Internet banking services can be programmed to automatically update your computer files if you are using one of these packages to manage your finances.

To do Internet banking, you launch your Web browser software, then when you are online, enter the address for your bank's Web banking site. You sign in by entering the number on your banking card, plus a password. You can then do practically everything you would normally do at a branch.

That includes getting information. On their Internet sites, banks have financial calculators to help you plan your retirement or figure out how large a mortgage you can afford. You can even apply for a loan electronically.

But there are other places to get financial information. Quicken Canada (www.quicken.ca) has information on subjects such as tax planning and mortgages, as well as quotes on securities and mutual funds. "Quicken Canada is an impartial source of financial information for Canadians," says Peter O'Brien, vice-president of Rogers New Media, which operates the site, "and we have links to all the banks in various places on the site."

There Is Cash in Those Chips

Debit cards are tremendously popular with Canadians. However, they are not very useful for small purchases. To fill this void, Canadian banks are experimenting with electronic cash, where value is stored digitally on a "smart card." When you want to make a purchase, you hand the card to a retailer, who transfers the value to his card. Because there is no need for bank authorization, and because there is no need to make change, transaction time is very short—two or three seconds.

In Guelph, Ont., Canadian banks are conducting a trial of an e-cash system called Mondex. The 12,000 Mondex card holders in Guelph can transfer funds from their bank accounts to their Mondex cards at CIBC and Royal Bank ABMs and from specially equipped pay phones. There are even special telephones that let users perform Mondex transactions from home.

Mondex is accepted by over 600 merchants in the Guelph area, and can be used on the city's parking meters and buses. With Mondex, one individual can transfer funds to another individual's card, so that you can use Mondex to pay the pizza delivery person or babysitter. Mondex Canada plans to extend the trial to Sherbrooke, Que.

Scotiabank is conducting a trial in Barrie, Ont., of a different system called "Visa Cash." Visa Cash is accepted at over 500 Barrie merchants, on the city's buses, and in the cafeteria and vending machines of Georgian College. The 22,000 cardholders can be customers of any bank. They transfer funds to their Visa Cash cards using 100 special loading machines located in stores and banks.

Meter made A woman pays for public parking in Guelph, Ont. with her Mondex card These parking meters are the only ones in the world that are Mondex-compatible.

Marlene Boyaner, vice-president, Smart Cards for CIBC, says Mondex's chip-to chip technology gives it some advantages over other cash card systems. It supports secure person-to-person transactions (directly, or over telephones or the Internet).

Visa Cash users don't have to register the cards or bank accounts, counters Bob Lounsbury, senior vice president card products and marketing at Scotiabank. They just pick up the cash card, and use their current debit cards to transfer funds to the cash card. "Our card is simpler," he maintains.

Shopping at the Digital Mall

If technology forecasters are correct, we are going to be making a lot fewer trips to the store in a few years. International Data Corp. of Framingham, Mass., predicts that the worldwide value of commerce carried on over the Internet will grow to $237 billion U.S. in 2001 from $12.5 billion last year. The most rapid growth will be in business-to-business transactions, as more and more companies use the Internet to control inventories of materials. But the value of consumer transactions will grow rapidly as well, to almost $60 billion in 2001, from $5 billion last year.

From a consumer point of view, there is a simple explanation for this growth: convenience and selection. Larry Stevenson, president and CEO of the Chapters bookstore chain, says the Internet bookstore his company is creating in conjunction with *The Globe and Mail* will be able to offer several times more titles than can be displayed in Chapters' huge retail locations.

From a business point of view, the explanation is just as simple. Not only does an Internet store have far broader reach than a retail store, it is far cheaper for businesses to offer goods online than to display them in a retail location.

Internet commerce works best where the product is a known quantity. While it is hard to tell from a Web site whether you will like an article of clothing, if you are looking for a specific CD or book, online shopping is a good bet. In fact, two of the most recognized names in Web commerce sell books (amazon.com) and records (Music Boulevard). Not only do they offer a huge selection, they have reviews to help you find records and books you will like.

In fact, even if you do not actually buy a product online, the Internet can be a wonderful research tool. If you are in the market for a car, you can visit automotive manufacturers' Web sites to check out options, prices and leasing arrangements. That way, you will have a lot more information when it comes time to take some test drives.

Safe Online Shopping

When you want to buy a product over the Internet, you have to use a major credit card. Many Internet merchants will let you give credit-card information over the phone, but is it safe to send this information over the Internet?

Most online stores use secure sites. When you make a transaction, a feature in your browser software called "Secure Socket Layer" (SSL) scrambles credit-card and other information, so that it cannot be used by anyone other than the merchant.

Lynn Anderson, enterprise marketing manager for Hewlett-Packard (Canada) Ltd., says 56 bit SSL (one of the more secure forms) can be broken in 15 days on a $1-million computer. HP has developed a

very secure 128-bit SSL encryption system for online commerce called "VerSecure." She estimates it will take up to 30 years to break that system. It uses digital signatures to tie transactions to a unique individual.

David Carter, marketing manager, Internet platforms at Microsoft Canada Co., says criminals are not likely to try to bust SSL. "It's easier to get credit card information by rifling through the garbage at a gas station," he says. "I've never heard of credit-card fraud on the Net. Your credit-card information is much more exposed in real life than on the Net."

The family that phones together. Maike Pilon and her children have fun keeping in touch with family and friends with their Clearnet PCS phone

Several companies, including Microsoft, are working on an Internet transaction scheme called "SET" (Secure Electronic Transactions) in which credit-card information remains encrypted all the way from the purchaser to the merchant's bank, so that not even the merchant can view it. There have been delays in bringing SET to market, but Carter says it will be deployed in the next 18 months.

Steve Gesner, vice-president interactive services at the Toronto Dominion Bank, advises Internet shoppers to exercise a bit of caution, but otherwise not to worry. "One of the things that customers are unaware of is that in the case of unauthorized use of your credit card, your liability is limited to $50. My advice is to deal only with reputable suppliers you know. It's like going to New York City. If you go into bad parts of town, you'll get hurt. Use common sense as you would with traditional credit card use, and make sure you use at least 40-bit SSL security to protect your credit-card number." ■

Talk Anywhere, Anytime

It's for you. Digital PCS wireless telephones like this Nokia model with a Fido network, allow callers to talk anywhere, anytime

More and more Canadians are cutting the cord that connects them to the telephone network. New Digital Personal Communications Services (PCS) wireless telephones are becoming very popular. The Canadian Wireless Telecommunications Association predicts that 40 per cent of Canadians—13 million altogether—will own a wireless phone by 2005, compared with 14 per cent today.

PCS service has several advantages over regular cellular telephone service. Because it is digital, sound quality is better and it is private. It is impossible to eavesdrop on PCS conversations. Dropped calls are much less common. Battery life is several times greater with digital PCS service than analog cellular. For most users, PCS service is significantly cheaper than cellular.

Canada's PCS providers include Cantel AT&T, Clearnet PCS, Microcell (which operates the Fido network), and Mobility Canada, which includes Bell Mobility. They offer different features and rate plans. Here are questions to ask if you are shopping for PCS service:

1. Where is digital service available? Most PCS phones are dual-mode types, so they will work in areas where there's only analog cellular service. But using the analog cellular network decreases battery life.
2. When you are outside the area serviced by the PCS provider, can you use your phone? If you are a frequent traveller, ask how and where you can use your phone when you are on the road, and what it costs.
3. Which rate plan best matches your calling pattern? For example, if you plan to use your PCS phone mainly on weekends, look for a plan with unlimited calling on them. If you make calls from within a restricted area, you may be eligible for billing discounts.
4. How big is the local calling area? Where can you call before you have to start paying long distance charges?
5. What does the package include? Some providers include calls made from cellular areas in your monthly airtime package. Others charge extra. Some charge for airtime by the second from the time a call begins; others charge by the minute. Some include voice messaging and Caller ID in your monthly plan. Others charge extra.
6. What are the terms of the contract? Are you getting locked into a rate plan for a long time, or can you change easily if competition drives rates down?
7. What optional services are available? Some services have text messaging so that your phone also acts as a pager, and options that let your portable phone receive e-mail.

gradual but dramatic improvement in the safety of open-heart surgery. Dr. Hugh Scully, chief of cardiac surgery at The Toronto Hospital, notes that the risk of dying during elective coronary bypass surgery is currently less than two per cent, down from 5 to 10 per cent when he began practising in the early-1970s. Risks have declined even as surgeons have taken on sicker patients and performed more complex procedures—replacing valves and doing bypasses in a single operation, for example. "The mortality rate from surgery across Ontario is now as low as any major centre around the world," says Scully.

Along with advances, demand has skyrocketed. Cardiologists performed almost 17,000 angioplasties in the year ending on March 31, 1995, up from about 1,000 a decade earlier, according to the Heart and Stroke Foundation of Canada. At the same time, surgeons performed just over 15,800 bypass operations, almost twice as many as in 1984-1985. "No one really knows what the right rate of service is for most of these procedures," observes Dr. David Naylor, CEO of the Institute for Clinical Evaluative Sciences, a non-profit health-services research organization in Toronto. "Canadians tend to fall between the British, with their very restrained approach to high-technology medicine, and the Americans, who have been leaders in adopting high-technology and more invasive approaches."

Rising demand has created lineups for surgery and occasional horror stories about patients dying on waiting lists—though that rate is just .4 per cent of heart patients in Ontario. Each province has its own method of monitoring and admitting patients, but only Ontario maintains one list of all patients awaiting open-heart surgery, and ranks them according to need. Mark Vimr, executive-director of the provincially funded Cardiac Care Network of Ontario, says patients are placed on the list once a surgeon decides they require an operation, and are ranked by the severity of their symptoms. On March 31, there were 1,138 patients listed, with an average wait of 46 days, down from 1,483 patients and 94 days a year earlier.

The decreases, Scully says, can be attributed to the fact that Ontario's surgeons, like their counterparts in most parts of the country, are performing far more operations than in the past. For example, the University of Alberta Hospital now does 30 open-heart surgeries a week, up from 15 in 1991. At the Health Sciences Centre in St. John's, Nfld., the number is expected to hit 550 this year, up from about 400 in 1997. The result, for the typical cardiac surgeon, is a punishing workload. Scully says he and his colleagues work 82 hours a week on average, up from 60 five years ago. "I don't know any who don't work six days a week," he says. "And on Sundays, you see half the surgeons in here checking on patients."

Cardiologists also say that while patient loads have risen sharply and lineups lengthened, the provinces have not created systems to manage access to their services. Consequently, patients may spend more time waiting to see a cardiologist than they do for surgery—a problem generally overlooked amid the public interest in lineups for heart operations. "Nobody talks about how long it takes to get from a general practitioner to a specialist, or the inequities that occur," says Dr. Charles Kerr, a Vancouver cardiologist who specializes in the treatment of irregular heart rhythms. "A person in northern B.C. often waits much longer than someone in the city. They often wait four to six months."

However, the medical profession is paying close attention to the outcomes of coronary care. Since 1993,

ROCKLAND FOR MACLEAN'S

David: two or three operations daily and up to 450 annually

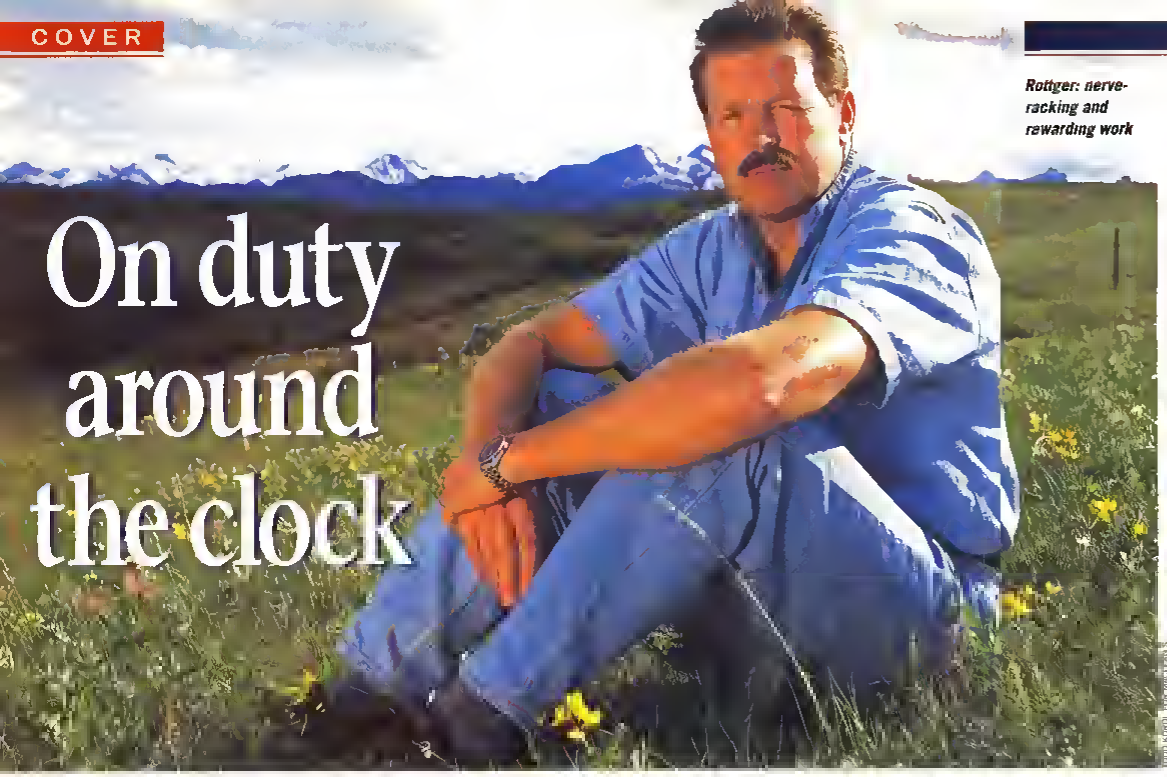
Rising demand has created lineups for surgery

Naylor's institute has kept track of Ontario patients who undergo heart surgery and die before being discharged from hospital—and found the mortality rate to be three to four per cent. And at Calgary's Foothills Hospital, Dr. Merril Knudtson heads a three-year-old study that tracks patients who received angiograms—in which dye is injected into arteries to detect blockages—in order to determine the type of care they received, the cost and the results.

One of the most ambitious projects got under way last fall in Nova Scotia. Dr. David Johnstone, chief of cardiology at the Queen Elizabeth II Health Sciences Centre in Halifax, says researchers will collect data on 10,000 heart patients this year. They will first determine how many received drug treatments, and evaluate the outcomes, before moving on to look at rates of hospitalization, surgery and death. "We should be able to do things better," says Johnstone. "This reflects the changes that are going on in health care."

But for all the problems that remain, many former patients are more than grateful for the treatment they received. Murray Barron, now 41, a parts manager at a Saskatoon car dealership, suffered from a rare condition known as cardiomyopathy—a deterioration of the heart muscle thought to be caused by an incurable viral infection—for nine years before having a heart transplant in London, Ont., in October, 1992. He had lived with fatigue, periodic stomach pains and permanently cold feet due to poor circulation. "I'll never forget waking up in intensive care," says Barron, a father of two. "The first thing I felt was blood in the feet and lips. It was pretty amazing." A heartening outcome in the battle against a major killer. □

On duty around the clock



Rottger: nerve-racking and rewarding work

TODD KOROL FOR MACLEAN'S

BY MARY NEMETH

Dr John Rottger had already worked a full week when, at 8 a.m. on a spring Saturday, he was back on call for 48 hours. He knew he would be in and out of the small hospital in Pincher Creek in southern Alberta virtually around the clock. By midnight Saturday, the 46-year-old father of three and stepfather of two was home and in bed—only to awaken to take three phone calls, go back to the hospital at 4 a.m. to check on a sick child and then again at 9 a.m. to do rounds. By 8 a.m. on Monday, he had seen 66 people in emergency, in addition to his rounds among the hospital's 15 inpatients, to cap off a 110-hour week. His cases have ranged from three people with cardiac problems to a man with a dog bite on his throat and another who was kicked in the knee by a calf. He also examined the body of a drowned 82-year-old man. All in all, it was a typical shift for Rottger, who usually works six on-call days each month. "I find the most stressful weekends are when the hospital's jam-packed," he says, pausing between patients in the emergency room, "and you're trying to find someone well enough to send home."

It is exhausting and challenging, sometimes nerve-racking and often rewarding work. It is certainly not for the faint of heart. Yet many rural physicians who have been slogging away for years say they are tired now. They complain about long hours and on-call shifts, about scarce time and funding to keep up with all the training they have to do, and inadequate compensation for their work in some provinces—a combination that is making it harder to attract new doctors to rural life. Some 400 rural physicians in Alberta were planning to close their offices for a day this week. Saying that the $19 million the provincial government has agreed to pay over three years for rural on-call services works out to about $7 an hour (on top of their fees for each medical service), the physicians are demanding triple that amount. A higher payment, they argue, would attract relief doctors to give locals a break.

In Quebec, both urban and rural doctors were threatening to take action. The province's 7,200 general practitioners were planning to close clinics and private practices for four days starting this week in their contract dispute with the province. In British Columbia, meanwhile, the provincial government announced last week that it would pay rural doctors for on-call work, $20 to $30 an hour in addition to fees for services, more if they forgo those fees. That came four months after 22 northern B.C. physicians, later joined by rural doctors in other parts of the province, withdrew hospital services for everything but life- or limb-threatening conditions. Dr. Brian Brodie, one of the northern B.C. physicians, said the doctors have to decide now whether the government's plan is adequate. "To me, this is a starting point," Brodie said. In the meantime, the rural doctors have restored some hospital services, including obstetrics and some elective surgery.

Tom Euverman, mayor of Houston, one of the affected communities 630 km northwest of Vancouver, said that even if the doctors do accept the government's plan, it will be a year or two before a true assessment can be made. "It remains to be seen," he said, "whether this is going to increase the numbers of doctors coming to small rural towns in British Columbia, because that's been the bottomline problem for 10 or 15 years or more."

Rural Canadians have long been accustomed to a different standard of care than their city cousins. No one expects a neurosurgeon in every small Canadian town. "But the gap," according to Dr. Keith MacLellan of Shawville, Que., past president of the Society of Rural Physicians of Canada, "is widening now quite a bit." Medical advances and new technologies are part of the reason. As medicine becomes more specialized, many general practitioners are no longer trained to tackle some of the problems they used to handle—appendectomies, for example.

At the same time, even small budget cuts can have profound effects. The loss of a town's lone anesthetist, for example, might mean the end of all surgery, including caesarean sections—and, consequently, most obstetrics. MacLellan points out that of the estimated 560 Canadian hospitals that deliver babies, about 125 mostly rural hospitals do not offer caesareans. Although babies can generally be delivered quite safely in a hospital without caesarean capabilities, MacLellan says, many women travel to another centre up to two weeks before they are due, fearing that, if they experience trouble trying to deliver locally, they will have to be rushed in full labor to another hospital for a C-section.

Urban medicine has its own special challenges, of course. Many general practitioners do difficult, gritty work in inner cities, for example. And many GPs as well as specialists put in long hours. There may actually be a shortage of specialists in the cities, although that is in dispute. What is widely agreed is that rural areas face a shortage of general practitioners. Their numbers have fallen to about 4,140 in 1998, from about 4,870 in 1994, although the definition of rural can vary from year to year. "Many communities are significantly underserviced," Alberta Medical Association president Bill Anderson says. "Patients have a very tough time getting timely access to physician service."

> Rural MDs are in revolt over their worsening working conditions

The most contentious issue among rural physicians has been on-call service. While urban family doctors generally provide call services, as well, many can arrange to share that service with several colleagues. And they can refer serious cases to the nearest hospital and a specialist. The rural physician who refers patients to a hospital must meet them there. And that hospital often has no specialists. On-call for rural general practitioners can be as frequent as every other night, some of the specialists who do work in rural areas are on call virtually the whole time they are in town.

British Columbia's Brodie says that being paid a fee for each consultation, rather than an hourly rate has tended to work in busy emergency departments in large communities. Not so in small towns with only a handful of emergency cases each shift. A doctor would hang around town within five minutes of the hospital, waiting for those few cases, "and sometimes you do that for 24 hours and make five or 10 bucks an hour," he says. "If we paid an RCMP officer only for the 15 minutes at 2 o'clock in the morning when he broke up the fight at the cabaret, he probably would quit."

Frequent on-call obligations can be tiresome even if doctors are paid for their time. But most provinces have begun to offer some kind of compensation. Nova Scotia, for example, pays physicians at least $51.91 an hour for being on call at community hospitals, instead of a fee for each service. In Ontario, the on-call rate is $70 an hour. In Saskatchewan, rural doctors get either $20,000 a year or, in larger communities, $10 an hour on weeknights and $25 an hour on weekends, in addition to fees for services.

There is clearly more to rural medicine than on-call work though. And Pincher Creek is doing fairly well, as small towns go. It has six general practitioners serving more than 10,000 people, including 3,659 in town. But the number of physicians will be down to five over the summer and fell as low as three last January. Although there are no fully trained specialists in town, each physician has some advanced skills. Rottger has some training in trauma, internal medicine and obstetrics, for example. And he does endoscopy, using fibre-optic telescopes to examine the gastrointestinal tract. "If we have an elderly person with rectal bleeding, you're obliged to exclude cancer," he notes. Providing endoscopy in Pincher Creek means those patients get the highest standard test without driving an hour and 15 minutes to Lethbridge while prepped with laxatives.

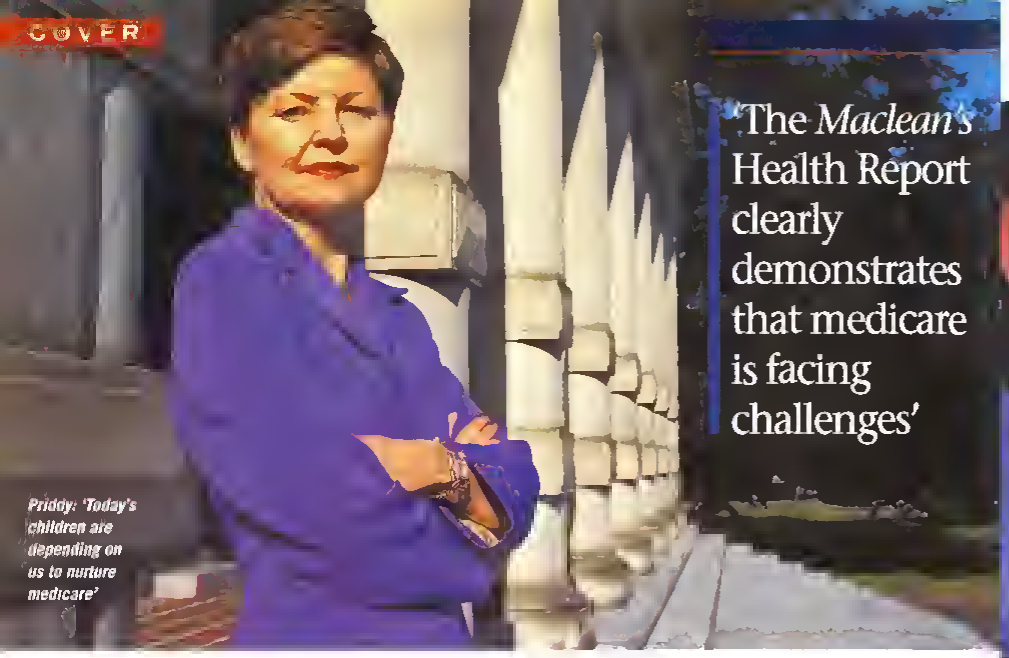
Still, the hospital has only 31 long-term care beds. That means some lifelong Pincher Creek residents have to be shipped to other communities. And at times, the staff has had to squeeze up to 24 acute-care patients into what is supposed to be a 16-bed acute-care wing.

The doctors, meanwhile, often feel run off their feet. Rottger says that he starts earlier now than when he began his rural practice 15 years ago. "Our mealtimes are much shorter and we finish later in the evening," he adds. Technology, the volume of continuing medical education and public demands are all taking their toll. At the same time, he says, provincial fee cutbacks coupled with inflation mean that his buying power is half of what it was 10 years ago.

But Rottger and his wife, Brenda, say they love Pincher Creek. They live on 10 beautiful rolling hectares a five-minute drive from town (although they are soon moving into Pincher Creek itself). Windsurfing on the Oldman River reservoir and hiking at Waterton Lakes National Park are close at hand. And most important, Rottger says, the work can be challenging. Six years ago, he was skiing at a nearby hill when a 12-year-old boy hit a tree. Rottger immobilized the unconscious child's neck, straightened his broken leg and started an intravenous drip. Then, an ambulance rushed the child to Pincher Creek with Rottger in close pursuit, dialling ahead on his car phone to prepare his partners.

Rottger concluded the boy was bleeding from an artery inside his head. He had seen the necessary procedure performed once, but had never done it. "The fact of the matter was the child was going to die unless we did something." So, with the help of a page of faxed instructions from a Calgary neurosurgeon, he drilled a hole in the boy's skull to relieve the pressure and save his life. Rottger praises his colleagues and the ski patrol and the paramedic. But it was clearly a proud moment—the specialist's fax is framed in Rottger's home.

Still, Rottger says that unless rural medicine becomes more attractive as a lifestyle, the number of new physicians willing to take on the responsibilities of a rural practice will continue to dwindle. Rottger himself is not going anywhere, though. Fifteen years into a rural career, he says, "I still can't imagine doing anything else." □



Priddy: 'Today's children are depending on us to nurture medicare'

'The *Maclean's* Health Report clearly demonstrates that medicare is facing challenges'

Expert evaluations

The people who know Canadian health care inside out are the ones who spend their lives working in the system, who help design and shape Canadian medicare, who worh day-to-day delivering the care that Canadians take such pride in—and who have experienced the feelings of helplessness when things go wrong. Maclean's *asked eight such experts from across the country to comment on the issues raised in the first national Health Report. Some, like B.C. Health Minister Penny Priddy, are public figures. Others, like Nova Scotia rural doctor Bob Martel, are dealing with realities on the front lines of health care.*

Penny Priddy VICTORIA

British Columbia minister of health. Trained as a nurse, Priddy worked for 30 years in programs for children, families and people with disabilities before entering politics

If medicare is to continue serving Canadians, we must improve the system without abandoning the principle of universal access I believe the best way to do that is by looking beyond our traditional view of health care to consider ways of providing patients with a greater range of choices We have to educate ourselves about the lifestyle choices we make and how they affect our health My experience as a breast cancer survivor has taught me to take more responsibility for my own health Governments and health-care providers also have a responsibility to inform people about their health and health-care options

The *Maclean's* Health Report clearly demonstrates that medicare is facing challenges The vacuum created by the federal withdrawal of funding is causing Canadians to ask what role Ottawa has in health care Improving medicare takes more than goodwill British Columbia is one of the only governments to increase total health-care funding for seven consecutive years As a result, British Columbia leads every other province in per capita public spending for health care, despite federal cuts to transfer payments.

Expanding the role of nurses in health care is an important part of creating more choice and increasing access to care for patients. The success of medicare will also depend on how well we care for seniors But in charting the future of the system, we have to keep the interests of

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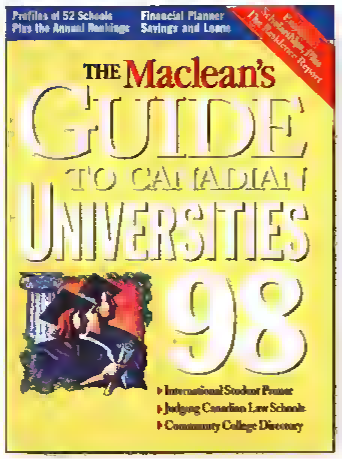

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WHAT MATTERS TO CANADIANS

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those it will serve tomorrow in sight. Today's children are depending upon us to nurture medicare so it is there for them when they need it. We cannot let them down.

Steven Lewis SASKATOON

CEO of Saskatchewan's Health Services Utilization and Research Commission. Lewis has been involved with health-care planning, research and evaluation since 1974

The Health Report tells us a lot about health care and less about health. It conceals more than it reveals. Much of this is not the fault of *Maclean's*: we do not have a lot of decent information about the quality of health care in this country, nor do we specify with any precision what the $76.6 billion spent in 1997 was supposed to produce, and for whom. Unfortunately, the utilization data tell us very little, and worse, they distract us from more fundamental issues surrounding the health of Canadians. Still, I think just beginning the discussion, as *Maclean's* has, may be very useful in getting the kind of information that is more truly indicative of what we've got, and what we don't have.

Despite fairly significant differences in per capita expenditures and the availability of physicians and technology by global standards, health status is pretty much the same across the provinces. Adding countries like Spain and Portugal to the international table would show that nations spending about half per capita than Canada have a healthy population. In any other industry, these data would occasion a spirited debate about overspending. In health care, it's always about scarcity—curious in light of the obvious diminishing returns from huge outlays.

Presenting interprovincial data washes out startling variations in practice within provinces and even municipalities. In Ontario, for instance, researchers at the Institute for Clinical Evaluative Sciences have published two major volumes that show huge differences in surgical rates from one county to the next. A quality health care system would have rigorous standards for assessing need and deciding whether, when and how to intervene.

The Health Report briefly touches on the most important cause of substandard health in Canada: inequality among classes. There is increasing evidence that our fates are significantly sealed by the time we are 3. No amount of miraculous health care can overcome the handicap born of deprivation. Despite the apparent cracks in our system (a worrisome and inefficient 31 per cent is now funded privately), we have access to a staggering array of health-care services. But huge disparities in health status persist, and Canadians should worry less about how many MRIs we have than about how many poor, unconnected, undervalued, underemployed, and irremediably ill remain among us.

Marion Suski WINNIPEG

CEO of Winnipeg Community and Long Term Care Authority. Suski, president of Victoria General Hospital before joining the authority in 1997, has also worked in hospitals in California and Minnesota

When I was the CEO of an acute-care hospital, the mandate was clear—reduce the number of patient days without compromising care. That worked well for some, like laparoscopic surgery or obstetrical patients, but for others it didn't. Mental-health patients, the frail elderly and those without family supports needed a bridge from the hospital to the community. Upon discharge, we lined people up at the front and back doors, wondering why community care, home care and long-term care couldn't respond.

Now, as CEO of the Winnipeg Community and Long Term Care Authority, I can see why. Budgets of hospitals went down and efficiencies went up. But the funding didn't shift appropriately to the community, which was dealing with an aging population, more people with multi-system diseases and people surviving more acute illnesses. In Manitoba, home-care volumes and expenditures went up and programs like home palliative care, supportive housing for seniors, adult day care, companion care, and other non-bed-based options are now being developed.

Acute care is portrayed as glamorous, with shows like *ER* dramatizing the crises, the high technology and the speedy recoveries. In contrast, community and long-term care deal with the realities of our streets and neighborhoods, like the issues of the frail elderly, fetal alcohol syndrome, drug use, sniffers and HIV. The results are often slower and more difficult to measure, but are no less important to our overall health.

We know now that people want autonomy: they want to manage their own care, and make their own choices about their lifestyle. In a sense, we have come full circle. We are reclaiming our traditional sense of self-reliance after four decades of trusting in institutional care. By definition, that means we must have a full spectrum of choices to meet individual needs. We must move beyond just health care teamwork to include the determinants of health, setting up

Decter, 'we need more consumer-level information to make intelligent decisions'

neighborhood networks that involve all partners, like education, justice, housing and family services to have a real impact on the lives and families of our communities

Michael Decter TORONTO

Health consultant and chairman of the Canadian Institute for Health Information An economist who has worked for two decades in senior public- and private-sector positions, Decter was deputy minister of health in Ontario from 1991 to 1993

Our approach to health services remains a great Canadian achievement With 9 2 per cent of our gross national product, we provide health coverage for all Canadians The Americans, who spent 14 2 per cent of GNP, have more than 40 million citizens without health insurance But we need better information in order to understand our own health and to manage our health system This is a period of unprecedented change from an in-hospital system of care to an ambulatory care world Patients providers, managers and policy-makers all need better information about the benefits and costs of various forms of care

Canada has badly under-invested in health information We spend roughly two per cent of the total health budget on health information. We would get better value for our total health dollar if we increased that vital investment to four per cent

The Canadian public is extremely concerned about access to health services as well as the quality, appropriateness and speed of those services Report cards should provide the public with information about those issues. The *Maclean's* Health Report is an excellent start, but we need more consumer-level information to make intelligent decisions

The provinces have started the tough work of reform over the past seven years, and the provincial ministers of health have borne the brunt of the criticism It is time for the federal government to provide real support in both leadership and dollars Federal funding for home care would be a good place to start. Medicare is what we make it. It can be as dynamic and modern as we choose. It can also be allowed to decay Medicare will be maintained not by putting it in a museum, but by reforming it.

Boisclair: 'governments are slow in developing home care'

Gordon Lever KINGSTON ONT

Co-founder, Victims of Health Care Abuse Lever became a patients' rights activist after his wife died at age 49 last September, less than a month after being diagnosed with stomach cancer

Our proposed motto states. "Let's put the 'care' back into health care" This, we feel, summarizes what is needed to rectify the system The badly planned and executed changes have resulted in low morale and many health-care providers fighting for their own survival How can one expect compassionate care in these circumstances?

Hospitals are very inefficient places suffering from too much bureaucracy and duplication Why are patients entering emergency asked the same questions and have the same tests carried out (temperature, blood pressure, etc,) three, four or five times? "Super nurses" trained in screening patients could be the first point of entry The nurse would then direct the patient to a "semi-specialist" who concentrates on several areas of medicine and therefore can keep up to date Clinics based on this idea could be equipped with many diagnostic tools, such as ultrasound, and result in "one-stop shopping" for patients

We also feel there are not enough specialists Seeing a GP can usually be arranged in a matter of days, whereas with specialists it can be many months More specialists are also needed if we are to take advantage of all the new information being generated in the field of medicine worldwide

The Health Report makes no mention of the huge increase in expenditure in the alternative medicine fields Every shopping mall now seems to have a health food/herbal medicine store and shelves in pharmacies are bulging with every sort of herbal medication possible When the amount being spent on this "private health care" is added to that spent on "public health care," you will find a substantial increase Overall, we feel there is enough money being spent; it is just going in the wrong areas Very little is spent on educating people, prevention early detection of diseases Too much is now spent on treating patients when it is too late and therefore very costly

Michèle Boisclair MONTREAL

Vice-president, Quebec Federation of Nurses

The *Maclean's* Health Report confirms that the recent transformations of the health care system were primarily designed to respond to the financial imperatives, first, of the federal government, then, of the provincial governments. The drastic cut in Ottawa's portion of health-care spending in the provinces (-22 4 per cent for Quebec over nine years) is worth highlighting On the other hand, the report does not break down the spending on health care within each province This breakdown would enable us to measure real spending trends compared with the national average We know that in Quebec, health-care spending is lower than the Canadian average Moreover, Quebec does not rank very well on important health determinants—incomes, education smoking and suicide The federation believes there is little political will to take positive action on health determinants. Combined with budget cuts at both levels of government, this contributes to the deterioration of the health status of the population

The absence of data on per capita investment in home care glosses over an important weakness in the transformation of the Canadian health-care system Home care should be a government responsibility but governments are slow in developing it.

The federation believes that personnel is a key element of any health-care system Yet there is a steadily growing exodus of nurses to the United States In Quebec, it exceeds that of doctors. Looking at the profile of personnel, Quebec is distinguished from other provinces by the fact that it has the highest ratio of doctors to population and one of the lowest ratios of nurses in Canada. Combined with the use of drugs and the development of technological facilities, this allows us to conclude that the Quebec government has opted for a health care system oriented more towards "cure" than towards "care" Yet the shift towards ambulatory care relies more on care

Dr. Bob Martel PORT WILLIAMS, N.S.

Chairman of the Atlantic regional committee of the Society of Rural Physicians of Canada.

The Canada Health Act guarantees all Canadians access to universal health care Unfortunately, there is little evidence to support that is happening in rural Canada. Geography has traditionally been the greatest barrier to access, but more recently the economic agenda of provincial and federal governments has conspired to further compromise Canadians who choose to live in rural Canada Regionalization, downsizing and rationalization of health services have been used as broad terms to explain the approach central health planners are using to restructure health care Unfortunately, the planners have been focused on indicators like hospital admissions, length of stays and more crude yardsticks, such as infant mortality

The problem with this approach is the focus A community is healthy when it is working together to support its residents, in times of prosperity and of economic downturn In closing community hospitals, health planners have failed to identify these institutions as more than a grouping of hospital beds But those facilities function as a critical link in the greater support system of a rural community Often serving as the centre of communication, the programs are interwoven into the social fabric where ladies' auxiliary social functions are as important as emergency services The other critical factor not identified is the tremendous economic impact these health-care jobs had on the community's economic base

Rural infrastructure expenditure reduction has threatened the ability of communities to provide the support required to keep its citizens comfortable with living in a rural area. Young professionals can no longer be guaranteed a quality of life conducive to professional and personal fulfilment.

Politicians who will eventually have to account to their constituents for the decisions being made are charged with the task of sensitizing their advisers to rural issues Forty per cent of Canadians are now saying that they need more attention or their way of life will be assimilated into the urban paradigm Rural areas are beginning to understand that they have been left out of the planning equation

Dr. Doug Sinclair HALIFAX

Chief of emergency medicine, Queen Elizabeth II Health Sciences Centre.

I support the concept of a periodic national report card to inform Canadians on the status of health care The system is undergoing massive, unprecedented change, and I see the frustration and confusion of both patients and staff every day The emergency department has become the barometer of the reformed system. It is a safety net as the pace of change of different parts of the system proceeds at different rates When overcrowding in emergency becomes significant, it is a warning that the system has become dysfunctional

Certainly, the fiscal agendas of the federal and provincial governments have driven the health-reform agenda. But what we forget is that the health-care system was in desperate need of reform, and it took fiscal belt tightening to finally kick-start many of the programs that we now support as part of the reformed system Some of the obvious examples include the trends to outpatient surgery and the expansion of home-care programs We must start to harness the power of the health-care providers and their local communities to truly drive the health-reform agenda, without battles over professional turf

All stakeholders in the health-care system have become increasingly frustrated with the lack of data to measure the effect of change on health outcomes Because the material presented in *Maclean's* is administrative data taken from large provincial data bases, it is not useful to many health-care providers on the front lines But it is a start. The true challenge now will be for communities and health-care providers to agree on a set of indicators to monitor the success of the health-care system Some examples could be the rate of successful use of clot busting drugs in heart attacks, the number of people successfully managed in a home-care setting and thus diverted from hospital, or the success of immunization programs

As an unusually optimistic health-care provider, I am excited by the pace of change I feel we have an enormous opportunity to make improvements, but the path will remain confused—and somewhat dangerous—for a while yet. □

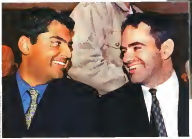
Reaching across the great divide

BY JOHN GEDDES

In another era, Rahim Jaffer would long since have been recruited into either the Liberal or Conservative folds Poised, personable and ambitious, he would, at age 26, be riding his abundant political skills towards an inevitable cabinet-level job But in a time of regional and ideological fragmentation, Jaffer's political career is on a much less certain trajectory As the most fluently bilingual member of the Reform caucus, the rookie Edmonton MP has been cast into a unique role as an emissary for western populism in Quebec. Last week, he ventured deep into what is, for most Reformers, terra incognita—Quebec City for a public debate with Bloc Québecois MP Pierre Brien. The next evening, the encounter, pitting Reform's concept of a decentralized federation against the Bloc's vision of a fractured one, was repeated in Edmonton. The exchanges between two regional movements that have redefined opposition politics in the House of Commons since 1993 were friendly—serving notice that Reform is willing to risk brushing shoulders with separatists in a bid to break out of its western stronghold and challenge the dominance of Prime Minister Jean Chrétien's Liberals "This has been by far our biggest opportunity to have our actual substance judged by a large number of people in Quebec," Jaffer told *Maclean's*

That is not necessarily much of a boast. Reform has been at best a political novelty in Quebec At worst, the party, which ran TV ads in last year's election campaign urging Canadians not to elect another Quebec-born prime minister, has been viewed as menacingly anti-French But if Jaffer's chances of winning over many Quebec voters are slim, his forays into the province might pay off in neighboring Ontario Softening Reform's image on the Quebec question could be the key to electoral success in Ontario—a breakthrough that eluded the party in 1997, denying it true government-in-waiting status. "I think Ontario had some misconceptions as to what our intentions are on the national unity file," Reform Leader Preston Manning said last week in an interview "If Ontario people get an idea of what we're really up to, that will help, maybe by relieving some fears."

If anyone stands a chance of persuading wary voters to give the party's ideas on unity that second look, it might well be Jaffer. He shatters the stereotype of the strident greying-around-the-temples Reform hardliner. An Ismaili Muslim whose family settled in Edmonton after fleeing Uganda in 1972, Jaffer has a proven knack for making white conservative voters feel at ease with a visible-minority candidate Even more valuable to the Reform party, he was educated mainly in French at the University of Ottawa While he still practises regularly with a tutor, he is bilingual enough to hold his own in Canada's other official language In Quebec City last week, an audience of about 150, made up mainly of separatists, greeted Jaffer politely But he is under no illusion about how well Reform's proposal for a reformed federation went over "I don't know whether we convinced a lot of people, and I somehow doubt that we did," he admitted "But if we get people thinking, then that's more than the Liberals have done in the past four or five years, that's for sure."



Jaffer (left) with Brien in Quebec City: 'It's hardly a first date, let alone a marriage'

Political opponents were quick to accuse Reform of going too far just by showing up for the debate Sherbrooke, Que , area Tory MP David Price suggested that by sharing a stage with sovereigntists, Reform was tacitly working with Quebec Premier Lucien Bouchard to break up the country "The Reform party has finally come out of the closet," Price railed in the House "It wants Quebec out of Canada" Liberal MPs joked that the two main opposition parties might merge as the "Rebloc" More substantially, political analysts pointed out that Manning seemed to be moving towards reconstituting the coalition that handed Brian Mulroney two massive majority Tory governments western conservatives who feel locked out of central Canadian power circles, bedrock Ontario Tories, and nationalist francophone Quebecers searching for an amenable federal party

Manning bristled at the suggestion he might be following in Mulroney's footsteps. "The coalition Mulroney built in Quebec was essentially done on a shmoozing basis, which was Mulroney's modus operandi," he said "We're starting with the principles, not the personalities, and we're starting at the bottom by distributing stuff to ordinary people " The principles that Manning hopes will build credibility, if not outright support, in Quebec are mapped out in his New Canada Act. The policy paper released last month calls for substantially strengthening provincial powers in areas like social services, language and culture, while bolstering Ottawa's clout in fields like interprovincial trade and the regulation of financial institutions But its most far-reaching proposal is to strictly limit the federal power to spend in provincial jurisdictions—historically Ottawa's main means of widening its sphere

Reform's forays into Quebec are aimed more at Ontario

Manning: willing to brush shoulders with separatists in a bid to expand his political base

Manning carefully refers to the package as "rebalancing,' rather than a "decentralization" of the federation But there is little doubt that the aspect of the message that won Jaffer a warm reception in Quebec City is the notion of curbing Ottawa's power—particularly Reform's call for giving the provinces unequivocal control over language and culture Reform strategists know better, though, than to hope for converts from the hardline Bloc and Parti Quebecois Instead, they aim to build bridges to the likes of Parti action democratique, made up mainly of former members of the Liberal Party of Quebec who favor decentralization just short of outright secession Mario Dumont, leader of the splinter party, said after the Quebec City debate that he was impressed by the "logic" of the Reform position More problematic for Reform is the icy relationship between Manning and Quebec Liberal Leader Jean Charest, who as federal Tory leader once called Reformers bigots, and rebuffed efforts to unite the two parties of the right. Charest's Quebec Liberal camp remains the natural home in provincial politics for many of the discontented federalists Manning wants to reach out to "Charest seems to be very personally offended by me," Manning said "But I think these ideas are bigger than personalities "

Pitching those ideas to what Manning calls a "soft sovereigntist" audience carries the risk of offending some of Reform's core western supporters In Edmonton, Jaffer felt compelled to declare that his friendly debates with Brien would not pave the way for formal Reform-Bloc co-operation "It's hardly a first date, let alone a marriage," he quipped

But if questions about cozying up to the separatists can be put to rest, some western political organizers predict that linking the aspirations of the obstreperous West and a discontented Quebec will sell well on the Prairies and in British Columbia—as long as Reform sticks religiously to its long-standing policy of no special status for Quebec "A soft approach to the underbelly of, if you will, the Quebec *politique* could be very attractive to westerners," says Dennis Reaburn, president of the Saskatchewan Party, the newly formed amalgam in that province of Reformers, Liberals, Tories and NDPers. Former Reform policy guru Tom Flanagan, a University of Calgary politics professor, agrees a hankering to make common cause between Quebec and the West is an old—though unrealized—notion in the Reform movement.

The backdrop to the remarkable Jaffer-Brien debates is the prolonged run-up to a Progressive Conservative leadership race The two leading contenders, veteran Tory strategist Hugh Segal—set to declare this week—and former prime minister Joe Clark, both can be expected to claim that the Tories stand a better chance of uniting Canadians under their leadership than Reform has under Manning So the pressure is on Reform to overhaul its reputation on the unity file before the Tories are back in the game A tone of urgency—and frustration—creeps into Manning's voice as he pleads for a fair hearing "Everyone objects to any initiative on this," he says "But I ask, 'What's your alternative?' Chrétien's approach is to just sit there like a lump and hope it's going to work out, or at least not fall apart until he is out of office That's not good enough We're prepared to push the envelope." □

CANADA

The fall of a senator

The Cogger affair fuels the debate over the Senate

Michel Cogger fell to earth last week. It has been a long, agonizing descent. The portly, peppery Tory senator and lawyer once helped run federal election campaigns, had the ear of prime minister Brian Mulroney, and the trust of legal clients like the shadowy Austrian businessman Walter Wolf. Driving his late-model Mercedes-Benz coupe, heli skiing in Austria and entertaining lavishly in his three homes, Cogger embodied the heady early Mulroney years. Now 59, his influence and homes are gone, and he drives a beat-up 10-year-old compact car. And last week, the ultimate disgrace: the Quebec court convicted him of influence peddling. "I don't know whether I can bounce back from this," a humbled Cogger told friends. "It might be possible for someone who is 20, but maybe not when you are 50 or 60. I am finding it very difficult just to function."

Cogger: fresh ammunition for critics of the upper chamber

There remains the option of an appeal. But after several years of fighting the charges against him, Cogger admits the financial pressures are "immense." The Supreme Court of Canada, meanwhile, has already had a say in his case. In July, 1997, it ordered the latest trial after Quebec courts had twice cleared him of illegally accepting $212,000 from a computer entrepreneur seeking $45 million in government grants to launch a new silicon chip plant in Quebec in the late 1980s. Jail seems unlikely, since a fine or community work is the normal sentence for white-collar criminals. (Pre-sentencing arguments are scheduled to be heard this week.) But Cogger could become the first person in history to be ousted from the Red Chamber under a constitutional subsection that says senators' seats become vacant if they are "convicted of a felony or any infamous crime." Meanwhile, another Conservative senator, Eric Berntson, is awaiting trial early next year on charges of fraud and breach of trust relating to his days as deputy premier of Saskatchewan in the 1980s.

For critics of the upper chamber, the Cogger affair has provided fresh ammunition. "It's a sick, sick place," crowed Reform party House Leader Deborah Grey. Earlier this year, the Senate was dogged by the Andrew Thompson case. Bad enough that the 73-year-old Ontario senator, who lives in Mexico, took his seat only 12 times between June, 1990, and December, 1997. But Thompson, a former Ontario Liberal leader, fought to hold onto his $64,000-a-year paycheque, while his fellow senators stripped him of his Ottawa office and secretary and finally forced him to resign.

The Senate seems unable to avoid controversy. Last March, Reform Leader Preston Manning questioned the appointment to the Senate of British Columbia's Ross Fitzpatrick, a close friend and former business associate of Prime Minister Jean Chretien.

who in 1987—when Chrétien was out of politics—arranged for the future prime minister to buy 10,000 shares in his company for $8 each, at a time when the stock was trading in the $12 range—a legal if friendly deal (A week later, Chrétien sold half those shares for about $17 each.) And last month, loud cries went up in Ottawa with reports that Liberal Senator Alasdair Graham, government leader in the upper house, had arranged for former Pierre Trudeau cabinet minister Allan MacEachen to remain at taxpayers' expense in a suite of offices on Parliament Hill almost two years after his retirement from the Senate at age 75.

Few observers would disagree that the Senate, which must approve any bill before it becomes law, can play a useful role by clarifying, simplifying and occasionally even halting flawed legislation. But the litany of bad press plays into the hands of the Reform party, for whom a Triple-E Senate—elected, effective and equal—is bedrock party policy. Cogger "is another walking, living argument on why the place should be reformed from top to bottom," Manning told *Maclean's* last week.

The New Democratic Party, meanwhile, wants the Senate abolished altogether. But the western provinces see reform of the upper chamber as a way to increase their clout in Ottawa. In 1989, Alberta staged an unofficial Senate election—the first and so far only one in Canadian history. Then-Prime Minister Mulroney refused to appoint the winner, Reformer Stanley Waters, to the upper chamber until June, 1990, when he was attempting to rally support for the Meech Lake accord. Alberta now plans to spend $2.5 million to hold elections for two vacant Senate seats next fall—and then pressure Chrétien into appointing the winners. And recent polls in British Columbia and Manitoba show both provinces want to elect their next senators.

Cogger's cautionary tale is the type that would only reinforce that trend. He owes his Senate seat to a friendship with Mulroney forged while they were both law students at Quebec's Laval University in the early 1960s. (Other Laval law students at the time included Tory Senator Michael Meighen, Quebec Premier Lucien Bouchard, Peter White, now one of media mogul Conrad Black's closest business associates and a former Mulroney adviser, and Bernard Roy, the Tory prime minister's principal secretary.) In the years that followed, Cogger ran Mulroney's failed 1976 leadership bid, then helped lead the 1982 movement that ousted Joe Clark as Tory leader and installed Mulroney in the leader's chair a year later.

No one was surprised in 1986 when Mulroney named the ebullient bilingual backroom operator to the Senate. But in 1991, the RCMP laid charges alleging that the senator had been pocketing payments from Guy Montpetit, an old law client, who wanted him to use his influence and contacts to get government grants. In 1993, the Quebec court acquitted Cogger, deciding that his actions were not motivated by criminal intent; in 1996, the Quebec Court of Appeal upheld the decision. But last July, the Supreme Court quashed those earlier rulings and ordered a new trial.

Now, Cogger seems all but broken by the seven-year court battle and the public humiliation of his conviction. He has told friends that he is "stressed out" and "devastated"—and has no idea what his next move will be. His fellow senators, meanwhile, are on the defensive. "The Senate cannot be blamed for the foibles of its members," stressed Alberta Conservative Senator Ron Ghitter last week. "To focus on the Senate simply because of things like Cogger is unfair." But perfectly understandable—considering the way things have gone lately for the upper chamber.

JOHN DeMONT *with* LUKE FISHER
in Ottawa

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Canada NOTES

A QUESTION OF LIABILITY

The B.C. Supreme Court ruled that the United Church of Canada and the federal government are financially liable for the sexual and physical abuse suffered by children at the Alberni Indian residential school. (Arthur Plint, 80, who worked at the Vancouver Island institution from 1948 to 1968, pleaded guilty in 1995 to dozens of sexual assaults on boys.) A future hearing is to set the amount of compensation.

RACIAL VIEWS

The Supreme Court of Canada unanimously ruled that prospective jurors can be questioned about their racial views to preserve the fairness of a trial. The case revolved around an aboriginal man, Victor Williams, who was denied the right to ask if any jurors might be "Indian haters" during his trial for a 1993 robbery. The court said Williams had a right to be concerned, given widespread bias towards natives.

MONEY FOR THE STERILIZED

Alberta said it will give up to $100,000 each to 504 people who were forcibly sterilized between 1928 and 1972. About 2,500 Albertans, designated mental defectives under the province's now-defunct Sexual Sterilization Act, were ordered sterilized by a government-appointed eugenics board.

SEEKING A REVIEW

Senior Nova Scotia Crown attorney Craig Botterill said he will seek a judicial review of a judge's decision to throw out a murder case against Halifax doctor Nancy Morrison. The respirologist was accused of first-degree murder in the November, 1996, death of a terminally ill cancer patient, but provincial court Judge Hughes Randall dismissed the charge in February, saying he did not believe the Crown could make a case that could result in a murder conviction.

IN THE BLACK

Nova Scotia's minority Liberal government staked its future on what the opposition called a "fanciful" budget, promising balanced books, an electricity rebate for consumers and more money for education and health care. Finance Minister Don Downe projected a $1.2-million surplus in 1998-1999, apparently delivering on the oft-repeated campaign promise that helped his party salvage 19 out of 52 seats in the March 24 provincial election.

Responding to the allegations

JONATHAN HAYWARD/CANAPRESS

Eggleton, a policy of zero tolerance

In the wake of the *Maclean's* reports on sexual assault and harassment in the Canadian Forces, the National Investigation Service of Canada's military police has set up a task force to deal with both new and old allegations of sexual misconduct. So far, of the 26 cases cited in the May 25 and June 1 issues of *Maclean's*, the seven-member task force has determined that only three had been properly investigated. Of the rest—all of which will be looked into—15 had not been investigated at all before, two will be reopened, and six cases need further review. Other cases, meanwhile, continue to come to the military's attention, especially through calls to the Forces' new sexual harassment hotline, 1-800-290-1019. "We're keeping busy," says Capt. Bud Garrick, operations officer of the NIS. "The calls come in constantly. What we have to do is assess each one to determine if it's harassment or a sexual offence, and from there it's assigned appropriate priority. As you can imagine, with this 1-800 number, people are using it for other means as well. There's all sorts of complaints coming in on it."

Last week, the military was rocked by fresh scandals. At CFB Edmonton, the NIS charged a private in the Princess Patricia's Canadian Light Infantry with sexual assault, assault with a weapon and uttering threats in connection with an alleged May 28 assault on two civilian women. As well, two other soldiers on the base were suspended as Edmonton city police and the NIS investigated a complaint by another civilian who alleged she was sexually assaulted by soldiers at the base on the night of May 30. Maj. Douglas Martin, a military spokesman, said soldiers in Edmonton "are very upset" by the new allegations. "It's a sad reflection on ourselves. It's not the behavior of a Canadian soldier, not the behavior we condone as Canadian soldiers. It's a kick in the guts."

Chief of Defence Staff Gen. Maurice Baril has personally contacted some of the sexual assault victims who have stepped forward in *Maclean's*. Recently, he also set in motion an investigation into alleged sexual misconduct within the 62nd Field Artillery Regiment in Shawinigan, Que., after receiving an anonymous letter. Last week, the NIS said it had found no evidence of criminality in the Shawinigan case, but one officer was suspended and a board of inquiry was set up to investigate allegations that the officer had relationships with several subordinates—which is against military protocol. Maj. Marc Rouleau, a Montreal-based spokesman, says the Shawinigan situation is "disturbing," coming on the heels of an unrelated allegation of sexual assault by a Shawinigan-based soldier in February. That incident is still under investigation.

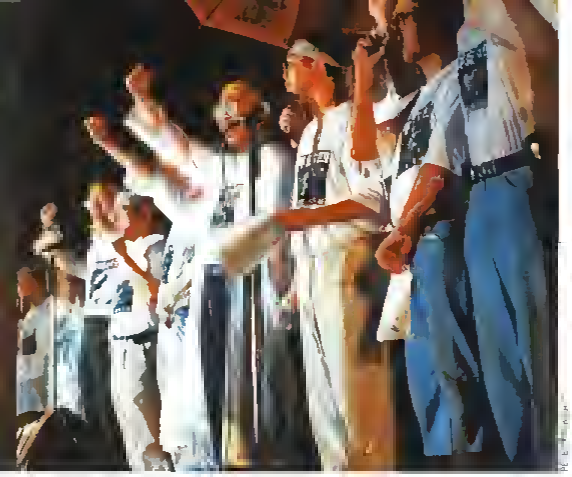
Meanwhile, in the House of Commons last week, Defence Minister Art Eggleton continued to face criticism from the opposition. NDP Leader Alexa McDonough, for one, took aim at the military's previously slow response to individual assault allegations. But Eggleton declared that action is now being taken. "We have put in place the mechanisms," he said. "And we put in place the training—to make sure we show support for our policy of zero tolerance."

Tory Firing

Anger over Bombardier

Setting aside its own guidelines, the federal government awarded an untendered $2.85-billion defence contract to Bombardier Inc. The 20-year deal to purchase and maintain equipment for training NATO jet pilots is the biggest single government contract in Canadian history. Industry Minister John Manley defended the decision, saying the Bombardier group was the only one in Canada capable of the work. The Liberals' move provoked outrage in the Commons reminiscent of the response to the Tory government's 1986 decision to award a $1.8-billion CF-18 contract to a Montreal firm despite a technically superior bid by a Winnipeg company. The ensuing tide of western anger was pivotal in the 1987 birth of the Reform party, and last week Reform MPs accused Ottawa of again playing favorites.

Soldiers march outside Beijing's Great Hall of the People; Tiananmen protest in Hong Kong (right): a long shadow



World

The China syndrome

Clinton's visit faces flak over rights, nukes and cold cash

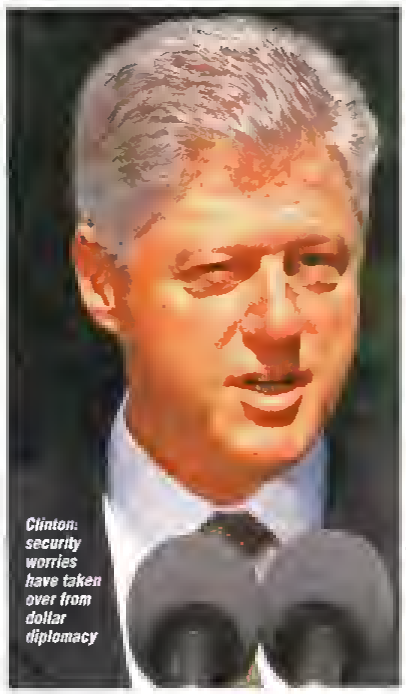
The deep thinkers at the White House had a plan. By the last week of June, they thought, their boss would need a break—badly. Paula Jones's sexual harassment lawsuit against him was set to start on May 27. It was sure to be messy and embarrassing. President Bill Clinton was due to visit China sometime in 1998, probably in the fall. Why not move the trip up to June, just in time to change the subject dramatically from sex and scandal to security and statesmanship? The President, went the logic, could stop acting like a defendant and start acting like the world's pre-eminent leader.

Oops. In Clinton's troubled second term, reality has had a way of rudely intruding on all such schemes. Who could predict that the Jones case would suddenly evaporate, tossed out of court by a judge on April Fool's Day? Who could foretell that another scandal, involving an alleged attempt by the Chinese government to buy influence at senior levels of the U.S. government, would resurface just as the President was packing his bags for Beijing? Or that a brand new controversy about whether a major Clinton campaign contributor illegally funnelled sensitive missile technology to China would add to his woes? Or, finally, that Asia's political balance would be rocked at just the wrong moment by a nuclear race between India and Pakistan—abetted in part by China's long-standing military aid to Pakistan?

ANDREW PHILLIPS
IN WASHINGTON

Any visit by an American leader to China, at any time, was bound to be controversial. Last week showed that this visit, by this President, at this time, will be thornier than ever. For one thing, it marked the ninth anniversary of the massacre of pro-democracy demonstrators at Beijing's Tiananmen Square, a trauma that still haunts China's politics and casts a long shadow over its relations with Western nations. In Beijing, police once again patrolled the square to ensure that no protests took place. But Chinese anger still surfaces where it is allowed to: in Hong Kong, which retains considerable autonomy despite its return to China last July. 40,000 people turned out, unmolested by authorities, for a rainy memorial to the dead.

During Clinton's nine-day visit to China, starting on June 25, he will be formally welcomed by Chinese President Jiang Zemin at a ceremony just outside the Great Hall of the People on the edge of Tiananmen Square—symbolism that enrages American critics of both China and Clinton. No matter that Tiananmen has been the traditional welcoming place for foreign dignitaries for decades, and the leaders of Japan, France and Britain, among others, have recently paid their respects there. By a vote of 305 to 116, the House of Representatives last week urged him not to go to the square. Just to rub it in, two House committees chose the anniversary to hold emotional hearings on charges that China sells the organs of executed prisoners to foreigners.



Clinton: security worries have taken over from dollar diplomacy

That kind of manoeuvring is nothing new in the near-constant debate among Americans over China. Clinton was once among the critics, in 1992 he derided then President George Bush for "doing business as usual with those who murdered freedom in Tiananmen Square." The irony, of course, is that Clinton went on to preside over the biggest-ever push by American business into China. Led by industrial giants like Boeing, AT&T and Motorola, U.S. companies have fought hard for a share of the Chinese market—and to ensure that Washington continues to grant most favored nation trading status to China. Clinton announced last week that he will renew that status again this year, and Congress is expected to ratify it despite misgivings towards Beijing.

At the same time, though, the so-called dollar diplomacy of the 1990s is an early victim of the new jitters over Asia. The old idea—shared by the Chrétien government in Ottawa—was that business interests should lead the way in the post-Cold War world. Governments, went the logic, should help business by opening markets and greasing the wheels of trade. In Washington, at least, that strategy has suddenly gone by the boards. Back at centre stage are traditional concerns about nuclear stability, balance of power, and transfers of sensitive technology to potentially hostile countries. "The idea was that geopolitics didn't matter anymore," says Robert Manning, director for Asian studies at the Council on Foreign Relations in Washington. "It was all economics and globalization: we'd all eat Big Macs and be happy together. Now, we can see that issues like national security matter again."

Clinton and his aides argue that this makes his upcoming trip to China all the more important. The sudden instability in South Asia and the threat that other countries, such as Iran, might also acquire nuclear weapons underlines the need for a strong U.S. relationship with Beijing. Secretary of State Madeleine Albright went so far as to proclaim that Washington is building a "strategic partnership" with China, and last week flew to Geneva for a meeting of the five permanent members of the UN Security Council—chaired by Beijing. They called on India and Pakistan not to repeat their tests, and to join 149 other nations in signing the Comprehensive Test Ban Treaty.

But American anxiety over China is running high, and will not be eased by the time Clinton begins his visit in the ancient capital of Xi'an on June 25. The concerns are fuelled in part by China's strategic aid to Pakistan, designed to counter its rival India. Beijing has funnelled nuclear and missile technology to Pakistan for two decades while Washington turned a blind eye. "The fact is," notes Manning, "Pakistan would not have nuclear capacity or the ability to deliver a weapon if it wasn't for China." *The Washington Times*, a conservative paper with excellent sources among U.S. intelligence agencies, reported last week that the trade goes on: the Americans were tracking a Chinese ship carrying electronics and special metals to Pakistan for the country's missile program.

Still, what has got Washington in a grand flap about China are a pair of scandals involving something more mundane: the old political standby of cash-for-influence. First, is the simmering controversy over whether Asian contributors to Clinton's 1996 presidential campaign were part of a plan by Beijing to buy a voice in the U.S. political system. At the centre is Taiwan-born businessman Johnny Chung, who contributed $530,000 to the Democrats. The party gave back Chung's money in late 1996 after it was discovered that it came from foreign sources, and Chung himself faces charges of violating U.S. tax and campaign-finance laws. But the controversy came back on the boil after Chung told federal investigators that some of the money he gave to the Democrats came from a high-powered woman named Liu Chao-Ying.

Liu, it turned out, is a lieutenant-colonel in China's People's Liberation Army, a top executive at China Aerospace International Holdings, the Hong Kong subsidiary of a Chinese company that builds rockets and satellites, and the 39-year-old daughter of a top Chinese general. She met Chung in 1996 and formed a company with him. Now, U.S. investigators want to know whether she is the crucial link that proves Beijing used Chung and others to channel cash to Clinton's campaign—in effect trying to buy influence in the White House itself. Crucially, though, no evidence has surfaced to show that the Democrats knew the source of Chung's donations, or that it influenced any of Clinton's decisions.

Second—and potentially more damaging in the new atmosphere of nuclear concern—is the growing controversy over whether a company headed by a major Clinton campaign donor illegally transferred sensitive satellite technology to China. Bernard Schwartz, chairman of Loral Space & Communications Ltd. of Palo Alto, Calif., gave $870,000 to the Democrats in 1996. In February of that year, Loral hoped to launch a satellite atop a Chinese missile—a practice permitted by American law but requiring a special presidential waiver. The rocket exploded seconds after liftoff, and now U.S. investigators want to know whether Loral subsequently gave the Chinese technical information that would allow them to target missiles more accurately against U.S. cities.

In May, 1997, a Pentagon review board concluded that Loral had indeed damaged U.S. security. The justice department began an investigation to see if criminal charges should follow. (According to a published report last week, a senior vice-president at Loral told the China Aerospace Corporation in a letter after the explosion that the company wanted to ensure that Chinese rockets "have the best reliable record in the future"—and that "we will do everything in our power to help you.") But in January of this year, Clinton gave Loral a waiver to launch another satellite in China—a move that offered the company a huge advantage in its legal dispute with the government. Now, four congressional committees are investigating whether Schwartz's hefty contributions led to favorable treatment by the White House. Republicans are up in arms, and even some senior Democrats admit to concerns that Clinton's hunger for campaign donations may have undermined national security.

The President, of course, denies that. His aides point out that Bush, his predecessor, also granted waivers to allow American satellite launches in China—mainly because the United States simply cannot meet the huge demand to put communications satellites in orbit. But the optics could hardly be worse for Clinton, politically and strategically, as he faces a new and more dangerous world. □

World NOTES

LEWINSKY DUMPS LAWYER

Former White House intern Monica Lewinsky, under investigation for perjury and obstruction of justice over her alleged affair with President Bill Clinton, fired her outspoken lawyer, William Ginsburg. She hired two seasoned Washington attorneys to replace the Los Angeles-based Ginsburg, a malpractice lawyer who was criticized for tactical failures in dealing with special prosecutor Kenneth Starr.

NO BILINGUAL TEACHING

Californians voted to get rid of bilingual education, in which many Hispanic children are taught mainly in Spanish. Critics, including many Hispanics, said kids emerged speaking little English. Under the new system, students will undergo a year of English immersion. Opponents of the change, however, launched a court challenge.

AFGHAN QUAKE MISERY

Aid trickled in very slowly to hungry and injured victims of a severe earthquake in northern Afghanistan that killed up to 5,000 people. Efforts were hampered by bad weather, the remote location and a shortage of fuel for helicopters. Many people waited days for food in villages flattened by the quake, the area's second in four months.

NEUTRINOS AND MASS

A joint U.S.-Japanese scientific team announced that, on the basis of their research, neutrinos—subatomic particles emitted by burning stars—probably have mass. Other scientists hailed the finding as historic and said it could have profound ramifications on further research. For one thing, some physicists noted that if neutrinos have sufficient mass, they could exert a gravitational pull—and slow the expansion of the universe. Work conducted at the Sudbury Neutrino Observatory is expected to confirm the team's findings.

PAYING FOR CYANIDE

Saskatoon-based Cameco Corp. and its partner, the Kyrgyzstan government, promised to pay about $725,000 to residents of two villages in the former Soviet republic affected by a cyanide spill. A truck headed for the partners' gold mine crashed on May 20, leaking 1,700 kg of cyanide into a river supplying drinking water. Hundreds were hospitalized, and the death of one woman was blamed on the spill.

Derailed express; helping the injured: the worst crash since the Second World War

Disaster on a fast train

Germans were in shock and mourning after the devastating derailment of a high-speed commuter train that had been the pride of their country's transit system. At least 100 people were killed and about 200 injured after all 12 cars on the Munich-Hamburg InterCity Express, or ICE, jumped the track at 200 km/h and smashed into a bridge near Eschede, a village north of Hanover. After the crash, an eery quiet descended before the whimpers of children and moans of the wounded began. "As I lay in silence, the door was open and I watched the sky, until the first helicopter came," said one survivor later from her hospital bed. After rushing home from a visit to Italy, German Chancellor Helmut Kohl wiped away tears as he visited the scene of the country's worst train disaster since the Second World War. Rescue crews took nearly three days to recover bodies from the tangled metal. The passenger cars had separated from the locomotive and slammed into one another, causing the concrete overpass to collapse on top of some of them. The operator of the locomotive, unaware of what had happened, continued driving until a stationmaster hit an emergency brake two kilometres from the crash site.

After initial puzzlement, rail investigators said the accident was most likely caused by a wheel that broke several kilometres before it hit a switch in the track, triggering the derailment. They could not say whether metal strain or something else caused the wheel damage, and would not rule out sabotage. The ICE, which went into service in 1991, is known for its efficiency and good safety record. In order to restore public confidence, German authorities pulled the fleet of 60 trains off their scheduled runs to carry out inspections.

'Ethnic cleansing'

Refugees streamed into Albania from Yugoslavia's troubled Kosovo province as local leaders accused Serbian authorities of a new "ethnic cleansing" campaign. Many of the 12,000 refugees said Serbian military and police units had destroyed entire villages in their campaign against armed separatists in Kosovo, where 90 per cent of the population is ethnic Albanian. "The situation is on the eve of open war," said Albanian Foreign Minister Paskal Milo. He urged the international community to get tough with Yugoslav President Slobodan Milosevic, a Serb hardliner. German Foreign Minister Klaus Kinkel said NATO troops were prepared to intervene. Diplomats said they might move in to seal Kosovo's borders, which would prevent Serbian forces from making hot-pursuit raids into Albania, and cool tensions with Macedonia, which also has a large Albanian population.

Saving for school

PERSONAL FINANCE

RESPs are gaining in popularity

BY JOHN SCHOFIELD

Little Kathryn Ash has just about got her future figured out. The energetic eight year-old from St. John's, Nfld., wants to be a teacher when she grows up—although she sometimes changes her mind when she is angry with her father, Don, a high-school vice-principal. Her 12-year-old sister, Jessica, thinks her mission in life is to be a veterinarian. For Ash and his wife, Frances, 37, a Revenue Canada assessor, what matters most is whether the girls can afford the education they will need to realize their dreams. To help them along, the Ashes are taking advantage of a new federal grant that supplements their contributions to a registered education savings plan, or RESP, by 20 per cent a year. "It's motivating us to put more money aside," says Don, 39. "If someone wants to give you an automatic 20-per-cent return with no downside, I'll take it."

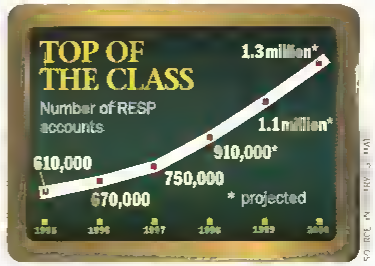
It's an offer many parents will find hard to refuse. And not only parents. Ottawa's Canada Education Savings Grant, introduced by Finance Minister Paul Martin in February's budget, is also open to grandparents and any other adult—whether related to the child or not—who wishes to contribute to a young person's education. The program, which is expected to cost taxpayers $150 million in its first year—has its critics, and navigating the thicket of rules surrounding it can be a challenge. But the government's 20 per cent sweetener, combined with growing concern over spiralling tuition fees, promises to make the once-unpopular RESP the hottest financial product since registered retirement savings plans—and a huge boon to the financial services industry. "Within three to four years," says Dan Richards of Marketing Solutions, a Toronto-based financial services consulting firm, "the majority of Canadians with young children will be taking advantage of this."

Preschoolers at a Toronto day care centre: dreams

For years, RESPs were ignored by investors, hobbled by their low contribution limits and other restrictions. But a little cosmetic surgery in recent years has vastly increased the allure. RESPs have always allowed for a variety of investments, from mutual funds to guaranteed investment certificates. Since 1996, however, Ottawa has raised the annual contribution limit to $4,000 from $1,500, and last year it allowed RESP funds to be rolled over into an RRSP if they are not used for a child's education.

Last February's grant announcement was the icing on the cake. Since then, some RESP providers report sales increases of as much as 50 per cent. And the number of RESP accounts, which stood at 750,000 in 1997, is expected to exceed more than 900,000 by the end of the year. The Big Six banks, which until recently only sold RESPs through their brokerage or trust operations, are moving quickly to sell RESPs directly. "There's nothing more motivating for a family than seeing their child get the right education," says Bruce Armstrong, director of retirement services at the Bank of Nova Scotia, which hopes to sell RESPs from its branches this fall. "We recognize the power of that with Canadians, and we want to be a part of helping them achieve those goals."

The grant is not without its problems. The regulations surrounding it, which consume nine pages in the government's detailed budget documents, can be confusing. Along with regulations imposed by Revenue Canada and Human Resources Development Canada, the federal department that administers the grant, investors have to contend with the rules laid down by each firm that offers RESPs. "They all have their own wrinkles, and each company differs ever so slightly from the other," says Monty Woodyard, manager of special projects at HRDC. "You really have to read the fine print."



The program also promises to be a bureaucratic nightmare for Ottawa. Multiple plans may be opened for one child as long as each contributor supplies the beneficiary's social insurance number and total contributions from all sources do not exceed $4,000 a year. HRDC expects to process as many as 32 million RESP transactions a year. It will be up to the companies that sell RESPs—there are now about 40, and the number is rising quickly—to report any excess contributions. In addition, account holders who withdraw money after collecting the grant will have to repay the grant—provided that the company fulfils its obligation to report it. The terms of the government's agreements with RESP providers are still being negotiated. "We're really moving fast and hard in every direction to get everything together," says Mary Flynn McRae, a senior program officer for the Canada Education Savings Grant. "It's going to be quite a job, but it's not impossible."

Along with the confusion, the grant program faces opposition from some student groups. Instead of spending taxpayers' money on handouts that will primarily benefit middle-class families, the government should provide more funding to post-secondary institutions and push for lower tuition fees, says Brad Lavigne, the 1997-1998 chairman of the Canadian Federation of Students. Failing that, the grants should go directly to students in need, he adds. The federation estimates that the cost of a four-year undergraduate arts degree, including living expenses, will rise from about $40,000 today to $67,000 by the time children born this year reach 18. The Bank of Montreal puts the future cost at about $75,000, based in part on an assumption that tuition fees will continue to rise—as they have so far this decade—faster than the rate of inflation.

RESP promoters do not hesitate to trumpet those figures. But rather than taking the federation's advice, the government is attacking big-ticket tuition fees with the forces that move financial markets. Ottawa and the financial services industry are both hoping that fear, and a bit of greed, will ensure that Canadians save for their kids' increasingly high-priced educations. □

HOW THE GRANTS WORK

The myriad rules surrounding registered education savings plans and Ottawa's new education grants could leave even seasoned investors scratching their heads. Some answers to common questions.

How do parents sign up for the grant?

Parents, grandparents or other adults wishing to contribute to the cost of a child's postsecondary education can take advantage of the grant by setting up an RESP through a mutual fund company, bank or other financial institution, which will apply for the grant on the customer's behalf. Several different types of RESPs are available, including individual plans that benefit one child, family plans and group plans that pool contributions from many investors. Self-directed plans for individual children or families may hold mutual funds, guaranteed investment certificates or other investments.

Can more than one adult contribute to a child's RESP?

Yes, but total contributions may not exceed $4,000 a year per child or $42,000 over the life of the plan. Under Revenue Canada rules, contributions may continue for 22 years and the RESP must be dismantled after 26 years.

How is the 20-per-cent grant paid?

Starting this fall, the money will be deposited directly into the RESP on a quarterly basis. The grant is paid on any amount up to the first $2,000 contributed in a calendar year. The last instalment is paid in the calendar year the child turns 17. However, the grant will cease in the year the beneficiary turns 16 if the account contains less than $4,000 or if contributors have failed to invest a minimum of $300 a year in any four years. (Ottawa is considering lowering those requirements to $1,500 or $100 a year in any four years.) To receive the grant, the beneficiary must be a Canadian resident and have a social insurance number.

Can grant-contribution room be carried over from year to year?

Yes. RESP holders whose contributions are too low to qualify for the full $400 grant in a given year may carry over the remaining amount to the next year. But the maximum contribution in any year remains $4,000, for a potential grant in the carry-over year of $800. If a child is the beneficiary of several RESPs, the grant is paid on a first-come, first-served basis.

Are contributions tax-deductible?

No, but earnings on RESP investments are sheltered from tax until the beneficiary enrols in a postsecondary institution and begins collecting income from the plan. Most students will pay little or no tax on RESP money because they typically have little or no other income.

What if the child does not go to college or university?

Parents who open individual or family plans may name another child as beneficiary, as long as he or she is a sibling by blood or adoption. If no sibling pursues postsecondary education, the face value of the grant—but not the interest—must be repaid to the government. Participants in some group plans also forfeit the interest on their money. Up to $40,000 in an RESP may be rolled over into an RRSP over two years, provided the contribution room is available. That limit will be increased to $50,000 next year. Money taken out of an RESP is taxed at 20 per cent above the contributor's usual tax rate. However, the tax burden can be spread over two years and split between spouses.

What can RESP money be used for?

RESP funds can be used for any education-related expense, including tuition, books, supplies and living expenses, provided the student is enrolled in a government-designated school in Canada or abroad.

Controllers in Toronto tower: the problems may get worse this summer

BUSINESS

Too much overhead?

As far as anyone on the ground at Calgary airport was concerned, May 21 was like any other day. Planes took off and landed with nothing more than minor delays. Ten thousand feet above the city, however, it was a different matter. For eight hours, the flight corridor between Calgary and Lethbridge was kept empty of airplanes because of a lack of air traffic controllers to monitor flights through the area. Nav Canada, the company that operates Canada's air navigation system, was so short of staff in Edmonton that it resorted to telling pilots who normally would have flown over southern Alberta that day to fly around it. One Canadian Airlines pilot en route to Vancouver went so far as to grumble on his jet's public-address system that he planned to stay in U.S. airspace as far as Bellingham, Wash., in order to stay as far away as possible from Canadian air traffic controllers.

A warning from airline industry insiders: get used to it. Across Canada, especially at larger airports, air traffic control problems are becoming increasingly common—and are likely to get worse this summer. The Canadian Air Traffic Control Association, the union representing Nav Canada's 2,200 controllers, blames cutbacks for staff shortages. The company, however, has accused the union of an illegal work slowdown following the workers' rejection of a March contract offer. Last month, the Canada Labor Relations Board sided with management, upholding an earlier ruling that forbids controllers from refusing work without a doctor's note. Officially, both sides say the labor dispute is not affecting traffic, unofficially, industry observers talk about disruptions such as the one over Calgary on May 21. "We have seen a number of incremental system delays over the past few weeks," says J. D. Lyon, who heads the Canadian Business Aircraft Association and sits on Nav Canada's advisory committee. "I understand they continue to have problems with the availability of staff."

The roots of the unrest can be traced back to 1991, when air traffic controllers were employees of the federal transportation department and their wages were frozen. Five years later, they were hired by Nav Canada, a private, nonprofit company controlled by the airlines. Nav Canada employees received generous government severance packages, and the right to retain government-style pensions and benefits, when they joined the private sector. (They also won the right to strike, which they did not have as federal employees.) So many years without a raise, however, meant high expectations when it came time to negotiate a new contract with Nav Canada.

At first glance, the deal Nav Canada is offering does not look bad. The lowest-ranked controllers working at the country's smallest airports now earn $51,034, while Toronto-based controllers make $77,058. Nav Canada is offering to increase those figures by between 11 and 38 per cent by 2000. But it is also pushing for a longer work week and other adjustments that bring the actual wage increase down to 12 per cent over three years.

The two sides are scheduled to meet again this week. But few people believe a settlement is close at hand. "We're headed into our busy season, so this is the perfect time if they want to create a disruption," said an employee of Pearson airport in Toronto. An Air Canada pilot, meanwhile, said he discovered while flying into the airport one day last week that there was only one controller in charge of two runways—a result, he believes, of staff shortages. "I don't think it was a safety issue, but as far I can remember it hasn't happened before," he said.

As bad as the situation may be in Canada, it appears to be far worse in the United States. Last week, technical glitches wreaked havoc: controllers monitoring the flight of Air Force One, with President Bill Clinton aboard, twice lost vital radar data on June 5; in another incident, a computer problem delayed hundreds of flights. Meanwhile, 10,000 U.S. air traffic controllers were ordered to undergo retraining after two jets, one of them an Air Canada A320, narrowly missed each other at New York's La Guardia Airport. Analysts said it was the latest in a series of errors caused partly by congestion at some of the world's busiest airports. By all accounts, congestion is not the problem in Canada. The big issue is money. Nav Canada's goal is to modernize the air traffic control system while reducing labor costs. Over the next months the process by which it achieves this may force Canadians to suffer through a lot of delayed or cancelled flights.

Air traffic disruptions are increasing

KIMBERLEY NOBLE

Deirdre McMurdy

Money on the move

What a difference six months can make. As recently as last December, experts were calling the economic crisis in Asia a containable, manageable "correction." Since then, the problems in the area have deepened and spread. Over the past few months, its financial markets have been subjected to continuous bouts of volatility.

That volatility, exacerbated by political upheaval in Indonesia and labor unrest in South Korea, has triggered a significant flight of capital from Asia to North American and European markets. Japanese investors bought a record $30.5 billion worth of foreign bonds and equities during the first 10 days of April. In the first five months of this year, about $70 billion sluiced out of Indonesia. And analysts think Asian cash represents a major chunk of the $5.8 billion that has been pouring into American mutual funds every week recently.

This exodus of capital has had three potentially far-reaching consequences. First, it has added fuel to the fires of North American equity markets. The injection of "hot money" has helped to keep share prices aloft, even as corporate earnings show signs of losing altitude. But it has also added a heightened element of uncertainty to the market, because Asian capital could leave town as quickly as it arrived.

> The exodus of capital from Asia has added fuel to the fires of North American equity markets

The second consequence of the Asian capital drain is that it has deepened the region's economic recession and delayed its recovery. In the last half of 1997, about $17 billion in private capital flooded out of Asia. And last week, despite government efforts to prop it up, the Japanese yen fell to a seven-year low against the U.S. dollar. That happened in part because Japanese financial institutions have become net sellers of their own currency.

But perhaps the most enduring fallout from the Asian downturn is the increasing pressure to limit the free flow of capital among countries. Until recently, it was generally accepted that free movement of capital—like free trade in goods and services—is the best way to ensure that markets function at optimum efficiency. In other words, capital will reward those who foster the best environment for it.

That assumption is now being challenged by a number of high-profile economists. Most of them focus their arguments on the existence of market imperfections—for example, unequal access to information—which distort capital flows and can cause severe damage in unsettled situations, such as the one in Asia.

Proponents of limiting capital flow also use the example of Chile to bolster their case. Since 1991, Chile has required that foreign investment remain in the country for a minimum period of one year. Furthermore, foreigners who invest in Chile must deposit 30 per cent of the money with the central bank for one year, without interest. Although the costs of capital in Chile are high—about twice the cost in neighboring Argentina—the country has produced the most stable economic growth record in Latin America. Chile has also been singled out as a free trade partner by Canada and is a member-in-waiting of the North American Free Trade Agreement.

Another element of the push to contain disruptive capital shifts comes, albeit indirectly, from Canada. At recent meetings of the International Monetary Fund and the Asia-Pacific Economic Co-operation forum, Finance Minister Paul Martin advanced the idea of an international watchdog to act as an early warning system for weak financial systems. As with the call for capital flow limits, that proposal is part of a broader ideological trend: the resurgence of central government influence and intervention as merged corporations expand their grasp and global markets mature.

Of course, curtailing capital movement is not a new idea. Economist James Tobin, for one, has long advocated a tax on "hot money" that would retard the speed at which it moves, and frequently disrupts, fragile economies. The debate may now be worth having, but Asia is a bad case upon which to base any thesis in favor of limits. That is because free-flowing capital is at its most destructive when, as in Asia, information is unavailable or incomplete, domestic banks are weak and government corruption distorts economic reality.

GM DENOUNCES STRIKE

The United Auto Workers called a strike at a key General Motors Corp. stamping plant in Flint, Mich. GM said the dispute could have "far-reaching consequences" because the factory supplies parts for some of the company's most popular and profitable vehicles, including full-size pickup trucks that are assembled in Oshawa, Ont.

EATON GOES PUBLIC

T. Eaton Co. Ltd. is selling stock to the public for the first time in its 129-year history. Investors placed orders for all 11.7 million shares at $15 each. The public offering, which closes this week, was expected to raise at least $175 million for the Toronto-based department store chain, which came close to bankruptcy last year, but is now restructuring. The Eaton family will own 50 per cent of the shares.

INSURANCE TAKEOVER

ING Groep NV of Holland, one of the world's biggest financial services providers, agreed to buy Guardian Insurance Co. of Canada from Britain's Guardian Royal Exchange PLC. Montreal-based ING Canada said the $544-million takeover will solidify its position as the second-largest property and casualty insurer in Canada, with nine per cent of the market.

BOEING TO CLOSE PLANT

Seattle-based Boeing Co. said it plans to close its suburban Toronto factory next year, eliminating 2,000 jobs. The company had earlier announced plans to lay off 850 of the workers. The final blow came when the company decided to halt production of its MD-11 jet, which uses wings built at the plant. Canadian Auto Workers union president Buzz Hargrove called for government intervention to preserve the jobs, but Ontario Premier Mike Harris said the plant is not worth saving if it cannot compete.

COMPETITION INQUIRY

The federal competition bureau is delaying a planned joint venture between Petro-Canada of Canada and Texas-based Ultramar while it considers how the deal would affect oil refining and gas retailing. The joint venture, operating primarily in Quebec and Atlantic Canada, would have $8.5 billion in annual sales, 3,500 gas stations and 300,000 heating oil customers.

Bre-X founder dies of stroke

Walsh: questions remain

The man Bre-X investors were counting on to solve the mystery behind the world's greatest stock fraud has taken his secrets to the grave. Mining promoter David Walsh, 52, died last week in a Nassau hospital, four days after collapsing from a massive brain aneurysm.

Walsh, born in Montreal to a wealthy family, followed his father into the brokerage business but, after a checkered career, began dabbling in mining ventures in the early 1980s. A large man who smoked and drank heavily, Walsh became a fixture in Calgary's penny mining circles. He showed great resilience when it came to his many business setbacks, bouncing back from personal bankruptcy to promote mining stocks out of his basement. In 1993, he gambled his last $10,000 to fly to Jakarta and track down John Felderhof, a Canadian geologist who had visions of precious metals lying undiscovered in the Indonesian hills. The two men later convinced investors that they had found the greatest gold deposit on the planet—right up until early 1997, when investigators confirmed that gold samples extracted from Bre-X's Busang property had been liberally salted with gold from other locations.

Bre-X collapsed, but not before Walsh and his family sold $45 million in stock and moved to the Bahamas. Walsh spent the last weeks of his life fighting a Bahamian court order freezing his personal assets, talking about starting an oil business and insisting that the raft of class action lawsuits filed against Bre-X and its managers would someday serve to clear his name.

Tobacco 'cave-in'

Canada's tobacco industry called it "a cave-in to common sense." Anti-smoking groups said it was a cave-in, period. The issue was Ottawa's decision to delay by two years a set of regulations that would have severely limited tobacco sponsorship of cultural and sporting events, including last weekend's Formula One auto race in Montreal. The rules were to have gone into effect on Oct. 1, but Health Minister Allan Rock, bowing to pressure from event organizers and tobacco lobbyists, agreed to postpone them until the year 2000.

Three years after that, Ottawa plans to impose an outright ban on tobacco sponsorship. But it remains to be seen whether that approach will work. The Supreme Court of Canada struck down an earlier attempt to restrict the industry's freedom of expression, and tobacco manufacturers have already launched a similar challenge against the sponsorship rules.

FINANCIAL OUTLOOK

Canada's economy expanded by 4.4 per cent in the year ending on March 31, but most economists believe the pace of growth will soon ease because of the spreading impact of the Asian financial crisis. The Conference Board of Canada, an Ottawa-based think-tank, is calling for growth of 2.9 per cent in both 1998 and 1999.

The jobless rate held steady at 8.4 per cent in May. The number of employed Canadians fell slightly, offset by a drop in the labor force.

"The number of help-wanted advertisements in newspapers increased again in May, suggesting that the modest decline in employment is likely to be temporary."

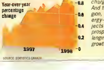
—Royal Bank

"Our merchandise exports to Asia, running close to $2 billion a month before the currency crisis, have dropped by 24 per cent in value terms."

—Conference Board of Canada

"Economic and job momentum is beginning to shift eastward. The western provinces, with the largest exposure to Asia's turbulence, are having a harder time keeping up with hard-charging Ontario. And the Atlantic region, where big energy-related projects are buoying prospects, is challenging for national growth leadership."

—Scotiabank



Peter C. Newman

Missing the *real* issue in the medicare debate

We sell off most of our profitable companies, we allow our politicians to lie to us, and we take being Canadian for granted, treating the Maple Leaf as a flag of convenience—or more often, inconvenience.

But there is one aspect of being Canadian that makes every citizen jump to attention: medicare. It is the one aspect of belonging to this large land north of the 49th parallel that is not negotiable. Being Canadian means never having to pay for having that boil lanced, those tubes tied, or your heart transplanted—and that's what makes us proud to "stand on guard for thee." We will give up our oil and our water, but any politician that takes away our right to visit doctors and not pay for it better head for the hills and stay there.

The problem with all this, according to Vancouver's Bob Modrow, who holds a doctorate in medical care organization, and epidemiologist Dr. Rick Mathias, both at the University of British Columbia's department of health care and epidemiology, is that we're putting the emphasis on the wrong end of the system.

What they contend in a groundbreaking article published in the March/April issue of the *Canadian Journal of Public Health*, is that our health-care system needs to be turned upside down. "If the purpose of the system is to improve and maintain the population's health," they write, "universality needs to be linked to outcomes." In other words, all of the energy of the bureaucrats who define medicare's parameters is now foolishly concentrated on providing every Canadian with an equal place in the lengthening lineups for service—even if the service is mediocre.

> Canada's health-care system must become just as concerned about the quality of care as it has been about accessibility

Hardly anybody seems concerned with monitoring the *quality* of the health service we receive. "Canadians have the right to demand a better health-care system, based on better outcomes," Modrow told me last week. "It could be so much more efficient and cost less, but all that the many commissions studying the issue have come up with is yet another package of recommendations that doesn't fundamentally change things. Bureaucrats just write another set of policies and procedures to achieve the same uniformity of process. They just change the words, upgrade the terminology, and they think they're evolving the system, but they are only evolving its vocabulary. It's strictly Alice in Wonderland."

What the authors of "Universality: Moving Beyond Access to Outcome" find so objectionable is that additional money put into the system is mostly dedicated to reducing the waiting time, and not what happens after a patient has surgery or is otherwise treated. "Of course, we need egalitarianism of outcome," says Modrow, "but everyone doesn't need to arrive at the same point in the same way. Some may have acupuncture. Some may benefit from Chinese medicine delivered in their own language, some may be flown to Calgary or Toronto for surgery, and so on. That may sound pretty obvious, but it's a revolutionary stance because our system doesn't allow us to arrive at the same outcome in different ways. There has to be some allowance for variability. When everybody does something exactly the same way, you can't tell whether they are doing it well or poorly."

These arguments are not esoteric. Anyone facing serious illness doesn't need much persuasion to be more concerned with the quality of care he or she receives than the fact that the treatment they get is identical, even if it is mediocre. "This is not an attack on publicly funded health care," Mathias says. "We just need to move to a different measure. The challenge is to make sure that the publicly funded system delivers a level of care that has outcomes within some kind of reasonably agreed on boundaries.

"How do we do that? It is not that difficult with all the health-care information systems that are being developed. With databases in every province on physician billing and hospital outcomes, there is a whole range of information available to us. We need to know that if somebody has heart surgery in hospital A, and B, and C, they all have an equal chance of doing as well as the other, and if they don't—why? That's where the crunch comes. We need to go to the places where the patients are not doing as well, and try to find out what the problem is."

Another concern the authors voice is the cost of having patients wait patiently in line, when some require service more than others. "For example," asks Modrow, "is it rational to make an elderly person wait nine months before cataract surgery, when we know that people with cataracts fall, and when they fall, they fracture things. There are measurable costs to this kind of delay, but they're not being dealt with, or even measured. The bottom line in the health-care system is health, not an administrative exercise."

The system must also be reformed to provide incentives for quality. The health-care debate should not be about hospitals, doctors, or administrators. It ought to be about what's happening to patients desperate to receive the best of care.

The writers suggest an approach that would achieve precisely that, plus allowing different approaches that promise a better chance for long- or short-term health.

Modrow and Mathias have brought into the open an essential issue that deserves a thorough national debate. To become the world model it deserves to be, medicare in Canada must become as concerned about the quality of care as it already is about its accessibility. In health care, more than in any other sector, before we worry about doing things right, we must be sure we're doing the right thing.

A Cup full of possibilities

Ronaldo fuels Brazil's hopes of repeating

BY BARRY CAME

Ronaldo playing in an exhibition game against Athletico Bilbao; the billion-dollar Stade de France (below): 32 countries will battle for what is arguably sports' biggest prize

Not a single bead of sweat mars Ronaldo's wide, unfurrowed brow. The young fellow is scarcely even breathing hard despite the exertions of the past 90 minutes. True, it has only been a friendly match, played within the sedate confines of a pretty tree-lined pitch in provincial France called Le Stade des Trois Sapins—The Stadium of Three Fir Trees. But the celebrated 21-year-old with the shaved head and gap-toothed grin was in the thick of it from start to end, enough to score the game's only goal and, along the way, offer tantalizing glimpses of his pace, power and sheer wizardry with a football. The very qualities, in fact, that have earned Ronaldo Luis Nazario de Lima his reputation as soccer's premier player and established his team, Brazil, as the favorite to once again capture what is arguably sports' biggest prize. "We have the talent to take it all," agrees the sturdy forward as he strolls off the field among the quiet oaks in Ozoir-la-Ferriere, a half-hour southeast of Paris. "But it's always dangerous to make predictions about something as wildly unpredictable as the World Cup."

None more so, perhaps, than the 16th version of the quadrennial world football championship that begins this week in Paris. When Ronaldo and his teammates face Scotland on June 10 in the glittering new Stade de France in the northern suburbs of the French capital, it will mark the opening match in a tournament rivalled only by the Olympics as a global attraction. Over the succeeding 33 days, teams from 32 nations will play 64 games, drawing 2.5 million spectators to football arenas in 10 cities scattered all over France. By the time the tournament winds up, it will have attracted a cumulative worldwide TV audience projected at 37 billion. Some 1.7 billion TV viewers alone are expected to watch the final contest on July 12 in the same Stade de France where it all starts, an 80,000-seat fantasy in glass and steel that almost floats, cloudlike, above the surrounding dreary industrial wastelands of suburban Saint-Denis.

It cost the French government $1.02 billion to build the stadium that is the architectural centrepiece of this year's World Cup. But that is just under half of the estimated $2.6 billion the authorities in Paris have spent so far for the dubious privilege of playing host to the football fever that grips much of the world every four years. The final bill is likely to be far higher, particularly if France's always feisty trade unions have any say in the matter. The country's airline pilots went on strike last week and similar action is being threatened by other groups: ground crews and cabin staff train drivers, even the police. There is as well, the ever-present peril of terrorist activity while the world's attention—through 12,000 accredited media representatives—is focused on France. To curtail that particular threat, police in five European countries rounded up close to 100 terrorist suspects two weeks ago, and last week the Paris government added another 1,000 troops to the 860 already on guard duty on French streets.

No matter what the hazards, the mood in much of France last week was clearly festive. The party is set to begin on the day before the opening kickoff with a five-hour pageant that will, according to Paris Mayor Jean Tiberi, "make your hair stand on end and your eyes roll." Four 65-foot tall mechanized giants—representing Europe, Africa, Asia and the Americas—will lead parades of 4,500 dancing, roller-skating cartoon characters, each moving from the four corners of the city to meet in the Place de la Concorde, where the Egyptian obelisk in the broad plaza has been transformed into an enormous replica of the World Cup trophy. "We'll have 80,000 people on hand there for a show," said Tiberi, "that will represent the essential sporting values of courage, self-denial, solidarity, friendship and brotherhood."

When the drama begins in earnest the following day, however, it will be Ronaldo and his teammates who occupy the centre stage. As usual, the Brazilians in their yellow-and-green jerseys are heavily favored to capture the trophy they have already won four times, more than any other nation. If anything, the team taking the field this year is even more formidable than the squad that won the 1994 Cup in the United States. Ronaldo, then a 17-year-old, was a member of that team but never got off the bench. Now the 5-foot, 10-inch, 165-lb. striker holds both the European and World Footballer of the Year titles. He has legs like muscled tree trunks, assets that give him lightning acceleration and the ability to shoot powerfully—and precisely—with both feet. Over the last four years, he has burned up every league he has played in, ending at or near the top of the scoring race with PSV Eindhoven in Holland, Barcelona in Spain and Inter Milan of Italy, his current club. Among the Italians, who know something about football skills, he has been dubbed Il Fenomeno—the Phenomenon.

What's more, he is a phenomenon with plenty of support. "Just look around you," Ronaldo remarked last week with a nod at the teammates filing off the field in provincial France. There was midfield general and team captain Dunga, 34; playmaking midfielders Leonardo, 28, and Denilson, 20; veteran goalkeeper Claudio Taffarel, 33; and the tiny 25-year-old Real Madrid left back Roberto Carlos, recently described by Brazilian sports minister and football legend Pele as "probably the best dead-ball kicker in the business today." A measure of Brazil's depth came last week when coach Mario Zagallo was forced to drop the injured Romario, the 32-year-old hero of the 1994 Cup. Zagallo has not one but two replacements ready to assume Romario's place as Ronaldo's attacking frontline partner—Bebeto, 34, another star of 1994, and the popular 26-year-old striker Edmundo, better known in Brazil as the "Animal" for his aggressive playing style.

England coach Glenn Hoddle, however, does not have an obvious choice to succeed Paul Gascoigne as a midfield playmaker. The 31-year-old "Gazza," like Romario a victim of advancing years and a libertine lifestyle, was a late cut from the English squad, a decision that provoked an outcry among some British fans and an acrimonious debate in the House of Commons. Given Gascoigne's deteriorating physical condition, Hoddle probably had no choice. But Gazza's absence leaves a huge hole in the English midfield, just as the earlier loss through injury of striker Ian Wright has caused problems up front. Still, there are bright spots for the English team, enough to earn the squad a ranking among London oddsmakers as the "best of the rest" behind Brazil and the other front-runners—Germany, Italy and Argentina.

England's main strength is the team's "spine." David Seaman, 34, in goal and Arsenal teammate Tony Adams, 31, on defence, with Liverpool's Paul Ince, 30, roaming the midfield and Newcastle United centre-forward Alan Shearer, 27, always a potent threat around the goalmouth. England also possesses one of the rising young stars of the game in 18-year-old Michael Owen. The fleet-footed striker has been a sensation in his first full season with Liverpool and, late in May in Casablanca, he became the youngest ever England footballer to score an international goal, breaking a record that has remained intact for the last 60 years.

On the question of records, there is another one that is giving the high-flying Brazilians cause for concern. Ever since the first World Cup was staged in Uruguay in 1930, only one non-European team—Brazil in 1958—has ever won the coveted trophy on European soil. In France, there are a host of European squads determined to see that it does not happen again. The pony-tailed Roberto Baggio is back in Italy's midfield, hoping that the country's third place in 1990 and second place in 1994 will result in something better in 1998. German striker Oliver Bierhoff scored more goals than Ronaldo in Italy this year, and Holland's Dennis Bergkamp almost beat the Brazilian for the World Footballer title. France and Spain, neither of which has ever won the Cup, are both fielding strong teams. And there are challengers from beyond Europe's shores—from two-time Cup winner Argentina led by goal scoring machine Gabriel Batistuta, and from Nigeria, the African nation that is deploying the same team that won the Olympic title two years ago.

The rest of the competing nations can pray for a miracle—and settle for simply advancing as far as possible. There are, to be sure, some intriguing curiosities, like the politically fraught match between Iran and the United States. Or the prospect of newcomers to the event—Japan, Jamaica, South Africa. And for those 140 disappointed countries, including Canada, that failed to qualify for a slot in France's tournament, there is always the reassuring prospect of better times ahead, when football fever once again spreads its grip four years from now. □

Heading for a photo finish: by a nose

BELMONT DRAMA

It was supposed to be Real Quiet's race. Despite a miserable record prior to the 1998 season, the three-year-old thoroughbred arrived at New York's Belmont Park riding high thanks to emphatic victories at the Kentucky Derby and the Preakness—and expected to capture racing's coveted Triple Crown. It would have marked the first Triple Crown win in 20 years. But Real Quiet crossed the finish line of the Belmont Stakes second, a bob of the head behind another three-year-old: upset winner Victory Gallop, bred by Toronto's Ivan Dalos—the first Canadian-bred horse to win the Belmont.

Last year's race also featured an upset as Touch Gold, American-bred but owned by Magna International Inc. president Frank Stronach of Newmarket, Ont., beat favorite Silver Charm by three-quarters of a length. This year's race was even more dramatic. With Real Quiet in the lead, Victory Gallop—owned by brothers Art, Jack and J. R. Preston of Prestonwood Farms in Texas—drew even after a tremendous stretch drive and won the race by a nose. For trainer Elliott Walden, it was a sweet victory—given that Victory Gallop had come within a length of beating Real Quiet in the May 2 Kentucky Derby. And while Walden expressed sympathy that Real Quiet had been denied the Triple Crown, he said, "I think it's fair to turn the tables."

With the win, Victory Gallop earned $870,000 for his owners. But a special bonus went undelivered. Visa International had promised $7.25 million to Real Quiet if the horse won the Triple Crown. It was not to be. "It's the survival of the fittest," said Bob Baffert, Real Quiet's trainer, before the race. "It takes a great horse to win it." In this case, Real Quiet fell just short of the mark.

JAMES DEACON

Horrocks with son Garrett, 10: 'we could have been a model for this province'

CHRISTOPHER MORRIS FOR MACLEAN'S

Back to the future

Students filing past Jeanne Zdyb in the cafeteria at Preville Elementary School in St-Lambert, Que., call out questions to their principal. Zdyb answers them, switching easily between English and French. Many children in this unusual school on Montreal's South Shore share the same ease in both languages, perhaps because Preville is one of a few Quebec schools that offers three separate programs under the one roof: English, French immersion *and* French instruction. Many parents—anglophone and francophone—believe that this mix helps their children polish their second-language skills. But Preville's days as a distinct school are numbered—a casualty of the massive reorganization of Quebec's school boards along linguistic rather than religious lines. After weeks of controversy, which saw some residents present a petition to St-Lambert city hall to get the school transferred to a local French board, the Quebec government came down with just that decision last month. The school's 386 anglophone students will move out by 1999 at the latest. "It's really a sad, sad thing," laments Debbie Horrocks, whose son and daughter are enrolled in French immersion. "What we had could have been a model for schools in this province." Francophone parent Johanne Purcell echoes that thought. "It was really the ideal."

Language rearranges Quebec's schools

The Preville saga is one of the more fractious episodes in the historic makeover of Quebec's school boards. By July 1, the province's 159 religious boards will be replaced by 72 linguistic boards (60 francophone, nine anglophone and three aboriginal), saving the system an estimated $100 million in administrative costs. And while most educators hail linguistic boards as a logical move long overdue, no one describes it as a walk in the park. "It's a mammoth undertaking," says Jeff Polenz, the head of the Quebec Association of School Boards, which represents the nine new anglophone boards.

The lengthy to-do list has included coming up with new board names, assigning staff, divvying up school properties and drawing up new bus routes. Simply finding an acceptable moniker proved frustrating for the Montreal-area Lester B. Pearson School Board. The anglophone board's original choice for a name—the Lower Canada School Board—was rejected by Quebec's commission in charge of formal names, prompting another language debate among the talk-show types. But the reorganization process has been especially onerous for the South Shore School Board, which runs Preville, because its mixed-language schools complicated the task. Next month, the board gets a new name (the Riverside School Board) and loses its 5,000 francophone students. It will also have to shift at least 2,500 of its anglophone students to new schools next fall. David D'Aoust, the board's director-general, says, "I think we should have had two years to bring this in properly."

Despite the time frame and some heated English-French battles over local schools, officials at Quebec's school board associations maintain that the transition has been relatively smooth. The greatest test will come in the fall. Some observers say there is potential for conflict over religion because individual schools will determine whether they want to retain a Catholic or Protestant hue, or become neutral. And amalgamated rural boards, saddled with huge territories, face equally large logistical problems. The new Eastern Shores School Board with 1,700 English-speaking students in 17 schools covers the Gaspé Peninsula as well as the communities of Baie Comeau and Schefferville on the north side of the St. Lawrence River. "Every time you have a [regional] meeting," says Stuart Richards, the board's director of educational services, "it will cost two or three thousand dollars."

Quebec schools must also grapple with another set of reforms being ushered in at the same time. Bill 180, passed last December, allows for greater autonomy of individual schools and gives parents greater decision-making power and a stronger voice in how their children are taught. The government maintains that both reforms are long overdue. But some, such as Ruth Rosenfield, the head of the Montreal Teachers Association, question the dizzying pace. "I think it's demented that we're making the two changes in the same time period," she says.

With the school board transition a few weeks away, D'Aoust acknowledges that there are definite benefits to linguistic boards. For example, Catholic and Protestant anglophone schools will no longer compete for the same enrolment and the English community can share resources. The South Shore School Board opposed the transition, D'Aoust says, because it liked the shared, bilingual quality of their system. That's the way many parents felt about Preville. Now, "it's going back to what I grew up with," says 39-year-old Horrocks. "The English walked on one side of the street and the French were on the other. And you never met, you never talked and you never played together."

BRENDA BRANSWELL *in St-Lambert*

Books

True amnesiac love

A leading historian says Canadians are neglecting the past

WHO KILLED CANADIAN HISTORY?
By J. L. Granatstein
(HarperCollins, 156 pages, $22)

Without question, Jack Granatstein has done *his* bit for Canadian history. The retired York University historian has authored 45 books, spawned historical journals, penned countless newspaper and magazine articles, and been a relentless popularizer of our collective past. He has earned the right to ask the obvious: how come Canada is probably the only country in the world not to teach a positive view of itself in a systematic way? The Americans do it in spades. The Dutch, the French, the English—you bet, right down to the last Tudor. But Canadians deride their own accomplishments as too boring or too disrespectful to certain groups. Or, worse, history is scattered about in a series of tabloid-style snapshots—Louis Riel, the wartime internment of Japanese-Canadians, conscription—in the process losing sight of the great muddy river of the Canadian experience.

Granatstein: his Lament for a Nation

Granatstein's thesis is that Canadian history has become the Latin of today's high schools and the university establishment. Yes, there are more Canadian history professors today than when Granatstein joined the York faculty in 1966, but they have broken into ever smaller factions, fighting over minor events and writing for the most part what Granatstein calls unreadable tenure-track sludge.

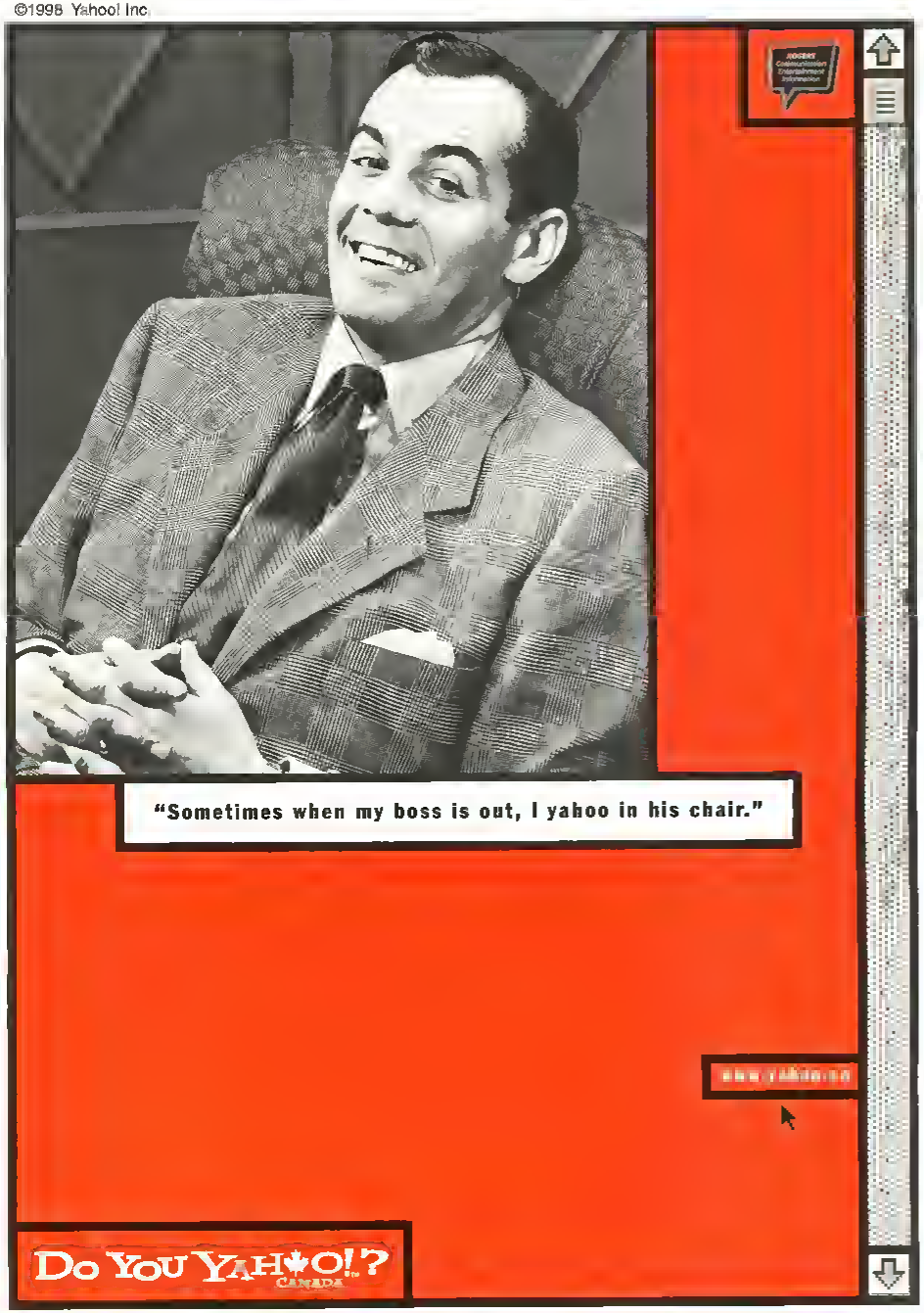
High schools, Granatstein argues, are also caught up in political correctness, made worse by a multicultural skein that has teachers overly anxious not to offend. As he puts it: "The history taught is that of the grievers among us, the present-day crusaders against public policy or discrimination. The history omitted is that of the Canadian nation and people." Meanwhile, the amount of history instruction is shrinking. In populous Ontario, the percentage of history courses in high schools dropped from 11.4 per cent in the mid-1960s to about half that today. Ontario, like most other provinces, now has only one compulsory history course in high school, called 20th-Century Canada and dismissed by Granatstein as "sociology-speak."

The author is conscious that he is a professional white male of a certain age arguing for more books and teaching of the politicians and other, largely white, males who have pushed and pulled this country forward. But that is the way it was, he contends, adding that chronology *is* important, chronology and context. Canadians cannot judge past events by today's standards. All they can hope to do is appreciate context for the simple pleasure of appreciating where they came from.

This is a slim, for the most part elegant, rant with only a few hobbyhorses being mounted. It is Granatstein's Lament for a Nation, seen through the prism of his own discipline, with a dollop of the Closing of the Canadian Mind thrown in for good measure. If it falters at all, it is as a whodunit. The author uses too broad a brush to compile his list of those who killed Canadian history—parochial-minded ministers of education, anti-elitist bureaucrats, warring small-minded intellectuals, ethnic communities "conned by Canada's multicultural policies into demanding an offence-free education," a media that search only for villainy. Broad generalizations are dangerous meat for historical inquiry.

But this is also a prescriptive book. Granatstein wants a minimum three years of compulsory history in public schools and a further three courses in high school, grounded in chronology and teaching both the political *and* social history of the nation. And he urges the federal government to establish an independent Centre for Canadian History as a first step on the road to a common curriculum. A shared history? In Canada? Yeah, right.

ROBERT SHEPPARD



People

Edited by TANYA DAVIES

Ginger snaps

And then there were four Just **Sporty** and **Scary** and **Baby** and **Posh** For **Ginger**—the oldest, brassiest and bossiest of the Spice Girls—has decided to call it a day She quit last week, citing "differences" with the other members of the British pop group that, in the space of only two years, parlayed what they call "girl power" into a $700-million empire Along the way, the Fab Five churned out a movie, two runaway albums and seven hit singles Though almost universally derided in the music industry as an artificially created mass-marketing tool, they managed to strike a chord among prepubescents Toronto Mayor Mel **Lastman** made international headlines last week after he revealed that he sent a letter to Ginger, begging her to return to the group and perform in the July concert in Toronto, for which his granddaughters, 11 and 8, have tickets "Please get over your differences," he wrote "I know you can work things out."

At the height of their popularity, the Spice Girls flirted with South African President **Nelson Mandela** and pinched **Prince Charles**'s bottom. Significantly, it was Ginger, whose real name is **Geri Halliwell**, who applied the naughty touch to the royal behind The 25-year-old's dyed red hair and skimpy clothing are in keeping with an earlier career that included stints as a nude model and a game show host on Turkish television Problems within the group have been brewing for some time, but the first public signs emerged last month when Ginger missed a BBC television appearance and two stops on a Norwegian tour Still, few expected a major break on the eve of the Spice Girls' upcoming 40-city North American tour, which begins on June 15 Last week, Ginger was hiding out in continental Europe, buttressed by a $30-million bank account and talking with the BBC about a possible TV show The remaining foursome, in the meantime, are determined to soldier on, declaring last week that they "are here to stay"

Baby, Posh, Sporty, Ginger and Scary the feistiest spice says farewell

Shaking his booty on the big screen

It has long been fashionable to mock the boogie-till-you-drop disco era, but filmmaker **Whit Stillman** will have none of that "I thought disco was a really great moment," the New Yorker says without a hint of irony "I think it has been reduced to camp and kitsch, and I wanted to rescue it " He has done that with his third feature, *The Last Days of Disco*, one of two releases this summer that get down (*54*, about the legendary New York City night spot Studio 54, starring Canadians **Mike Myers** and **Neve Campbell**, opens in August) Stillman's movie follows a group of preppy Harvard graduates in the early 1980s as they dance all night and suffer in low-paying jobs during the day "I did that," Stillman laughs

In fact, all three of his witty movies about young adults from affluent families are semi-autobiographical "I like to write about what I know," says 46-year-old Stillman Born in Washington, where his father was a political administrative aide, he graduated from Harvard in 1973, and dabbled in publishing and journalism before writing and directing his first film, *Metropolitan*, in 1990 The comedy follows a group of Manhattan debutantes, a circuit that Stillman was part of In 1994 came *Barcelona*, about Americans living in Spain—which he did in the 1980s In August, the filmmaker is moving to Paris with his journalist wife, **Irene** Perfect fodder for another film

PETER BREGG/MACLEAN'S

Stillman: 'disco was a really great moment'

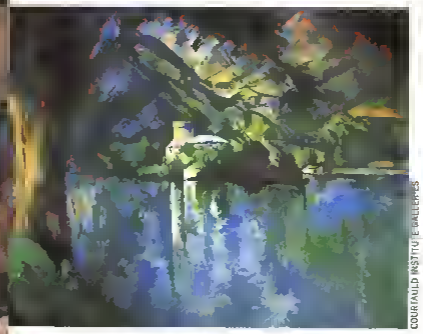
The eyes have it

It's a season of plenty at Canada's public galleries

The blockbuster may have been born in Hollywood, but it is also flourishing in the art world. This summer, public galleries across the country are offering an unprecedented number of cultural events featuring some of the world's greatest artists, including Rodin in Quebec City, Giacometti in Montreal, Picasso in Ottawa and the Impressionists in Toronto. Godzilla may be king of the box office but Picasso, Manet and Rodin look like hot tickets, too. A guide to some of the season's art extravaganzas:

BY SHARON DOYLE DRIEDGER

Many of the finest impressionist works line the galleries of the acclaimed Courtauld Institute of Art in London. At least, they usually do. This summer, art lovers intending to visit the venerable museum, one of the best in the British capital, will be disappointed to find that it is closed for renovations, and that the popular pieces have been shipped to the Art Gallery of Ontario in Toronto. The Courtauld Collection at the AGO (June 10 to Sept. 20) is the only North American stop for the exhibition, which was on view in Kyoto, Japan, earlier this year. With just 80 paintings and drawings, mostly impressionist and postimpressionist, it is not a huge exhibit. And the majority of works are small in scale—not surprising since the original collector, British industrialist Samuel Courtauld (1876-1947), displayed them in his home for several years before donating them to the British government. But size does not really matter in art. And the lineup of artists—including Manet, Degas, Monet, Renoir, Cézanne, van Gogh, Gauguin, Toulouse-Lautrec, Pissarro and Modigliani—guarantees that the Courtauld exhibition will be one of the top museum draws in North America this summer.

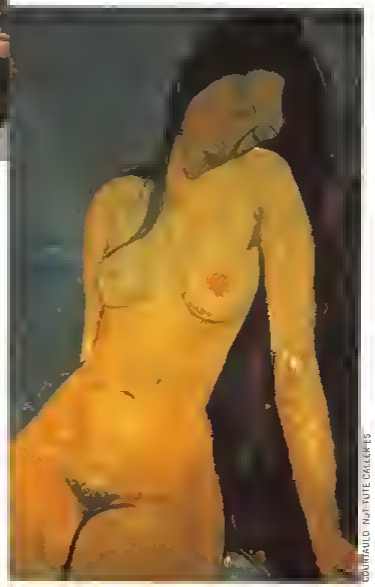


COURTAULD INSTITUTE GALLERIES

Manet's ***A Bar at the Folies-Bergère*** *(left);* ***Cézanne's Lac d'Annecy*** *(above): critics attacked the works of Impressionists as 'too messy'*

In a few short years, from 1923 to 1929, Courtauld assembled what amounts to a historical survey of one of the most beloved movements in art. By the time the rayon manufacturer began collecting, the importance of impressionism and predecessor impressionism had already been established. But Courtauld helped transplant the works' popularity to Britain, which had until then ignored modern French art.

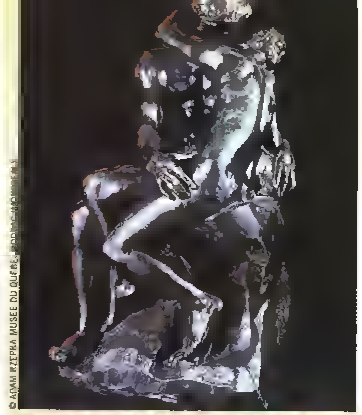
Displayed in chronological order, the show begins with pieces from the Impressionists' first group exhibit, held in a photographer's studio in Paris in April, 1874. "They were heavily attacked as too messy," says AGO curator Alan Chong. "Critics thought the Impressionists didn't know how to draw properly, their perspective was off, their works looked unfinished." But *La Loge*, one of seven paintings submitted by Renoir, was "a hit, by far the most praised picture, admired by conservatives and radicals," notes Chong. The instantly recognizable portrait of a woman at the theatre, gazing boldly at the viewer, her striking features softened in shimmering light, will likely prove its enduring appeal at the AGO.



COURTAULD INSTITUTE GALLERIES

Modigliani's Nude: *Courtauld built a priceless collection and popularized French artists in his native England*

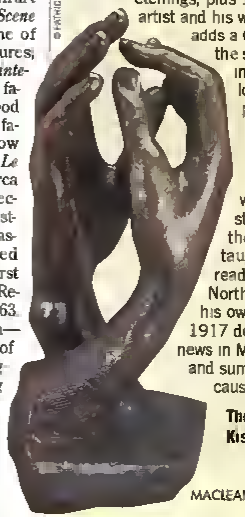
But this time around, *La Loge* will share the limelight with several other masterpieces—especially Manet's *A Bar at the Folies-Bergère* (1881-1882), perhaps the most analyzed painting in art history; Degas's *Ballet Scene* (1874), considered one of his greatest ballet pictures; and Cézanne's *Mont Sainte-Victoire* (1885-1887), a famous view of his boyhood home and one of his favorite subjects. The show also includes Manet's *Le déjeuner sur l'herbe* (circa 1867), one of the most recognizable images of Western art, but not the massive canvas that gained notoriety when it was first shown at the Salon des Refusés exhibition in 1863. The Courtauld collection owns a second version—sketchier, less detailed and less than half the size of the one now hanging in Musée d'Orsay. "It was originally thought to be a study," says Chong, adding that experts now believe this *Déjeuner* was duplicated much later by Manet for a private collector. That is just a tiny disappointment in a sumptuous visual feast. □



© PATRICIA ALTMAN-MUSÉE DU QUÉBEC/DRAC (MONTREAL)

RELISHING RODIN

Last month, Paris's Musée Rodin, the government-run institution that owns and manages the legacy of the celebrated artist (1840-1917), shipped five tonnes of Auguste Rodin's works—hefty sculptures in bronze and marble as well as delicate original plaster casts, paintings and drawings—to the Musée du Québec in Quebec City. That precious cargo represents a major coup for a small Canadian gallery. The 100 or so artworks, many never before shown in North America, will be featured in an ambitious retrospective of the sculptor's career organized by the Musée du Québec. Rodin in Quebec City (June 4 to Sept. 6) includes such famous creations as *The Thinker*, *The Kiss* and *The Three Sirens*. Also on view is a selection of pencil and ink drawings, watercolors and etchings, plus 17 photographs of the artist and his work. The exhibition adds a Canadian twist to the subject of Rodin. It includes 36 pieces on loan from private and public collections across the country. In fact, the exhibit's curator, Janet Brooke, notes that when Rodin was starting his career in the 1890s, the self-taught artist was more readily appreciated by North Americans than by his own compatriots. His 1917 death made front-page news in Montreal. This spring and summer, Rodin will again cause a stir in Quebec.

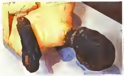


The Cathedral *(left);* ***The Kiss*** *(top):* ***more beloved in North America***

CANADIAN MUSEUM OF CIVILIZATION

EGYPTIAN ENIGMAS

Mysteries of Egypt, an ambitious new show that opened last month at the Canadian Museum of Civilization in Hull, Que., and runs until the spring of 1999, delves into the lost secrets of one of history's greatest civilizations. At its heart is an impressive collection of artifacts: papyrus paintings, jewelry, sarcophagi, human mummy masks, craftsmen's tools, mummified animals (cats, falcons and a baby crocodile) and hundreds of other pieces drawn from such major establishments as Washington's Smithsonian Institution and the Royal Ontario



SMITHSONIAN INSTITUTION

Human mummy; mummy mask (top): intriguing

Museum in Toronto. There are also full-size replicas of rooms from King Tutankhamen's tomb in the Valley of the Kings and a funerary boat bearing a copy of his golden coffin. Visitors can enhance their sense of life in the time of the pharaohs with a virtual-reality tour of King Tut's and Queen Nefertari's magnificent tombs. The exhibit also marks the debut of a new IMAX film, also called *Mysteries of Egypt*, starring Omar Sharif in a suspenseful story set amid the pyramids and their treasures. Neither the show nor the film pretends to unravel the riddle of the pyramids, but both vividly conjure up an intriguing civilization.

Cast of Michelangelo's Madonna and Child; Westwood's lethal shoes (below): classic and pop treasures

ECLECTIC AND ELECTRIC

It's a 10-km walk through the galleries of London's Victoria and Albert Museum, home to the largest and, arguably, the finest collection of decorative arts in the world. This summer, Toronto's Royal Ontario Museum will showcase some of the esteemed institution's most popular treasures in A Grand Design: The Art of the Victoria and Albert Museum. The exhibit—which runs from June 21 to Sept. 13 and is the only Canadian stop in an unprecedented North American tour—is an eclectic mix of the wild, the wonderful and the classic, with 250 paintings, sculptures, ceramics, fashion items and other objects stretching from antiquity to contemporary pop culture. A few highlights: a cast of Michelangelo's exquisite Bruges Madonna, the fig leaf used to cover the private parts on a cast of Michelangelo's nude David during Queen Victoria's visits to the museum, and the outrageously high, bright-blue mock-crocodile platform shoes by British designer Vivienne Westwood that caused supermodel Naomi Campbell to stumble on a runway in 1993.

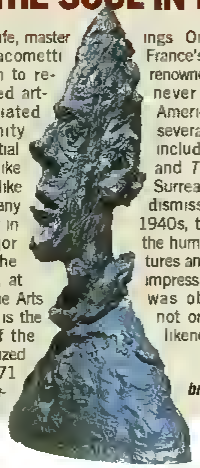
Nuxalk sun mask: fearsome

PUTTING THEIR BEST FACES FORWARD

The 18th-century British explorer Capt. James Cook failed in his quest to find the Northwest Passage, but he did not return to England empty-handed. On his journey up the west coast of what is now Canada, he encountered First Nations people who generously presented him with ceremonial masks, arrows, bowls and other gifts. Now, more than two centuries later, two of Cook's masks are back in Canada for the first time, on display in an intriguing exhibit at the Vancouver Art Gallery. Down from the Shimmering Sky: Masks of the Northwest Coast, which runs from June 4 to Oct. 12, is a magnificent collection of 175 historic and contemporary ceremonial masks created by native artists. The sculpted and painted wooden icons, many of them decorated with human hair, shell beads, fur, string, feathers and other materials, depict powerful ancestral spirits, in human and animal form. Among the most fearsome are cannibal birds, creatures believed to swoop down from the Sky World seeking human prey. In recognition of their legendary power, native leaders opened the exhibit with a dance to quell evil spirits.

CAPTURING THE SOUL IN BRONZE

Towards the end of his life, master sculptor Alberto Giacometti (1901-1966) began to resemble his acclaimed artworks—elongated, emaciated figures imbued with dignity, fragility and a certain existential angst. He looked, perhaps, like *Walking Man I*, a 1960 stick-like bronze figure and one of many famous creations that appear in Alberto Giacometti, a major exhibition celebrating one of the century's greatest sculptors, at The Montreal Museum of Fine Arts from June 18 to Oct. 18. It is the first major retrospective of the Swiss-born artist's work organized in Canada, and it features 171 sculptures, paintings and drawings. One-third of them are from France's Fondation Maeght, whose renowned Giacometti collection has never been shown in North America. The exhibit showcases several other celebrated works, including *Spoon Woman* (1926) and *The Table* (1933) from his Surrealist period, which he later dismissed as "worthless." By the 1940s, the artist began to focus on the human figure. Both in his sculptures and in his less well-known but impressive oil portraits, Giacometti was obsessed with capturing not only his subject's physical likeness but also the soul.



Large Head of Diego: *the brooding genius of Giacometti*

© ALBERTO GIACOMETTI/SODRAC (MONTREAL)

PROMETHEAN PICASSO

Picasso is indisputably the most famous artist of the 20th century. Love him or hate him, the man and his works are endlessly fascinating. So it is not surprising that Picasso: Masterworks from The Museum of Modern Art—an exhibit that opened at the National Gallery of Ottawa in April and continues until July 12, has already attracted more than 100,000 visitors. The show, with more than 100 works spanning seven decades, features such important paintings as *Three Musicians* (1921), *Girl Before a Mirror* (1932) and *The Charnel House* (1945). And by presenting the artist's paintings, sculptures, prints and collages chronologically, the exhibit clearly illustrates Picasso's stylistic evolution and inventive genius.

Boy Leading a Horse: *work spanning seven decades of inventiveness*

Allan Fotheringham

Government by muzzle on the Hill

There are, as it turns out, worse things than the threat of Bill Vander Zalm returning to active politics as head of the Reform in British California. Hard to imagine, but there are.

Even more tiresome is the relentless march of the Politically Correct Army, all in lockstep, knee-jerked, always searching with keen eye for what would appear to be cleansed, laundered with Rinso, in the public mind.

ROY PETERSON

The entire Parliament of Canada—that would be the Pizza Parliament of five parties—with valorous bravery voted unanimously to bar Ernst Zundel from speaking on Parliament Hill. This is the nutter, of course, who denies the Holocaust and wastes all our tax dollars by going through the courts when we try to shut him up.

So he calls a press conference on Parliament Hill? So the pumped-up little pipsqueak called Don Boudria, Liberal House leader, immediately introduces a motion: "That this House order that Ernst Zundel be denied admittance to the parliamentary precincts during, and for the remainder of the present session of Parliament."

Every proud member of Parliament, aware that their integrity, courage and intelligence was on the line, obediently fell into line like the barking seals they are. And said yessir, yessir, three bags full.

This was in the same week, if we may digress, while they were all preparing to approve legislation that would give them an eight-per-cent raise over four years, double their housing allowance, and allow qualifying Reform MPs who dumped their pensions to take a $100,000 lump sum payment instead.

The nonsense in all this could only be expressed by Gilbert and Sullivan. All the pomposity raised by the mountebanks and hypocrites who flesh out the Commons benches was in full flower. Secretary of State for Multiculturalism Hedy Fry—herself an immigrant from Trinidad—cried out: "This is probably the clearest example of a united front against a hatemonger. We're very pleased at Parliament's action in this case."

Sure you are. Simply because you can't think clearly. Better to listen to Alan Borovoy, himself a Jew, and general counsel for the Canadian Civil Liberties Association. His reaction? "I am afraid this is not a proper exercise of parliamentary discretion. It could be Zundel today and someone else tomorrow."

Of course it could. Next week? A prominent anti-abortionist? Or Dr. Kervorkian? Hedy Fry might sit down and have a quiet conversation with herself. The fact that the Parliament of Canada, which has other things to contend with—including loading up its pensions—would take the time to discuss one nutbar tells you a lot about Ottawa.

And the screwball Zundel? Of course, he took just one step away from Parliament Hill and held his press conference and got six times the coverage he might have got in the first place, where no one takes him seriously anyway. It's called free speech, which must be protected somewhere in the Charter of Rights—given to us by Pierre Trudeau, who believed in it so much he said "fuddle-duddle" to a member opposite in the Commons, though his actual words were somewhat shorter.

This proud Liberal government, exemplified by Boudria's pouter-pigeon outrage, is the same one delineated in the same week by John Grace, the dignified former editor of the *Ottawa Journal* who has served for seven years as Canada's privacy commissioner and eight as information commissioner.

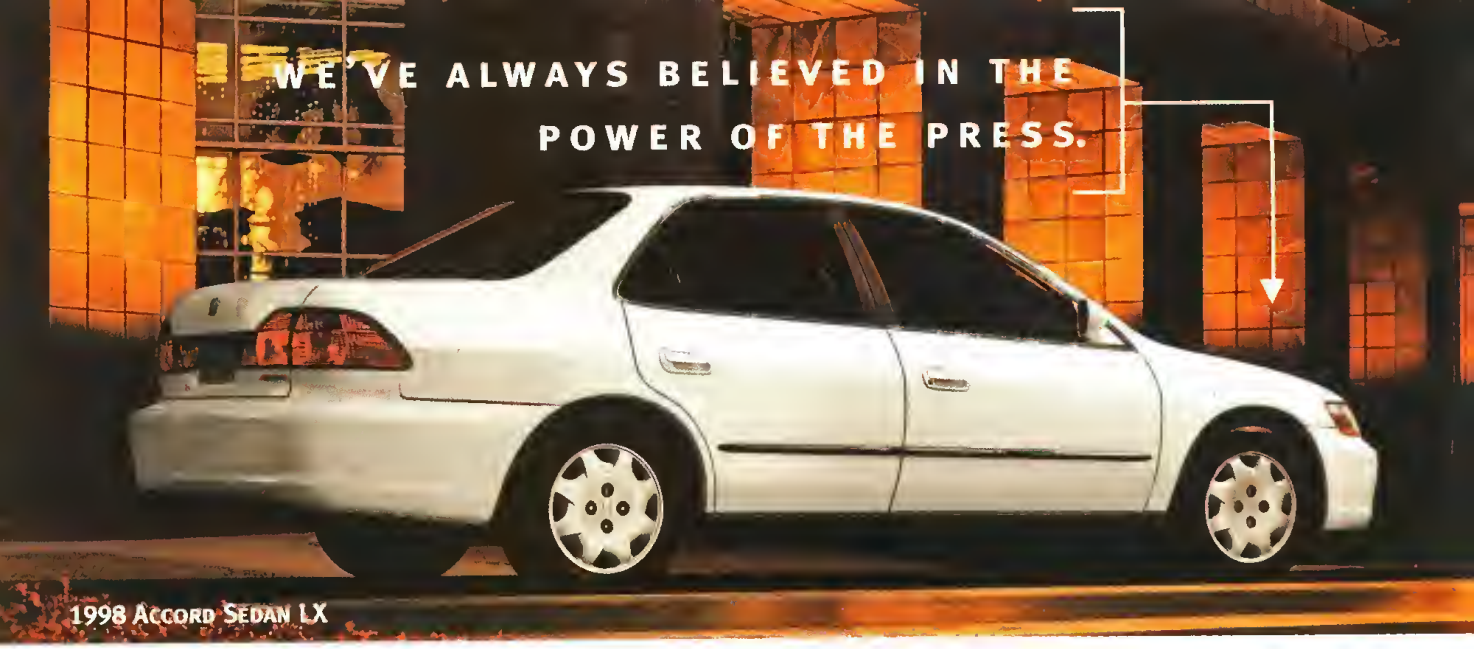
In his departing report he says quite flatly that "a culture of secrecy still flourishes" in the government of Jean Chretien—who, last time we checked, was Boudria's boss. After 15 years of the idealistic Access to Information Act being introduced, he found, the essential ethos of the high swivel servants was deny, deny, deny.

He quotes, in his report, the mantra of an old ward heeler in New York's Tamanny Hall days: "Never write it if you can speak, never speak it if you can nod, never nod if you can wink."

Which brought us, of course, to the now inscribed-in-the-language Monty Python line: nudge-nudge, wink-wink. Everyone knows what it means, especially the hordes of ex-cabinet ministers (latest being the horrible Doug Young) immediately appearing on Parliament Hill as pinstriped lobbyists pawing the lapels of this government that is so brave as to banish Ernst Zundel from the Parliamentary lawn.

Political correctness will be the death of all of us. The previous NDP Harcourt government in B.C. brought in legislation that eventually brought to court my old colleague Doug Collins, who grew so old that he needed publicity and called *Schindler's List* "Swindler's List," and so wasted a ton more of taxpayers' dollars by being prosecuted for it.

Better to spend our time, as John Grace suggests, on more serious threats to our freedoms. He didn't mention it, but I will. In Sweden, there is a rule. Everything government does must be open—except that which has to be deemed secret. In Canada, everything remains secret—except that which is deemed open. These guys are despicable.



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